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ABSTRACT

The monograph examines the rationale and scope of multidisciplinary teams in child abuse and neglect cases; and reviews operation of hospital-based, interagency, and state-mandated multidisciplinary team programs. The bulk of the document is composed of two appendixes: a directory of child abuse and neglect programs which use a multidisciplinary approach, and guidelines from Virginia and Pennsylvania on the operation of multidisciplinary teams. (CL)

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MULTIDISCIPLINARY TEAMS IN CHILD ABUSE AND NEGLECT PROGRAMS

A Special Report from the National Center on Child Abuse and Neglect

AUGUST 1978

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National Center on Child Abuse and Neglect
U.S. Children's Bureau
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Introduction

The emergence of the multidisciplinary approach in child abuse and neglect intervention and treatment has been described by DeFrancis as the result of a combination of the two other major models of child abuse and neglect -- the social service model and the medical model.[1] The multidisciplinary approach is in part an attempt to enlarge the theoretical framework by which child abuse and neglect are understood. Just as the social service and the medical models imply approaches to intervention, so the multidisciplinary model implies a way of intervening in child abuse cases. This approach involves the combination of social service and medical personnel into a coordinated unit - the multidisciplinary team. Although there are a number of variations on this basic combination, most multidisciplinary teams directly involved in the treatment of child abuse and neglect include medical and social service personnel.

A multidisciplinary team, then, is a team of professionals (which may include paraprofessionals) from a variety of disciplines, often representing different agencies, working together for a well-defined purpose or purposes. These purposes have included coordination, diagnosis or identification, prevention, treatment, consultation, and education.

Why Multidisciplinary Teams?

Child abuse and child neglect are problems which do not lend themselves to a simple treatment approach. In many cases of abuse or neglect there are injuries or physical problems which require the services of a physician for diagnosis and treatment. The abusive or neglecting parent generally exhibits some degree of psychological impairment, though rarely as dramatic as psychosis, which requires the attention of a mental health or social work professional. It is likely that the abused or neglected child may also require psychological or psychiatric intervention. Because the abusive or neglectful family does not exist in a vacuum, it is necessary to consider and perhaps intervene in the family's interpersonal and social environment. This is traditionally the province of the social worker. Besides counseling on interpersonal relationships, the social worker is also concerned with problems involving family sustenance and shelter. Finally, there is a legal aspect of child abuse and neglect, in which the police, the public prosecutor, and the courts may figure.

If one considers other aspects of the problem besides treatment, such as identification and prevention, it becomes clear that other agencies and professions are, or should be, involved. Teachers and other school personnel can help by recognizing the signs of abuse or neglect and becoming familiar with reporting procedures; public health nurses may be able to identify abused or neglected children, or help to prevent abuse and neglect by encouraging healthy parenting.

Child abuse and neglect are problems whose effective amelioration must involve the coordinated efforts of professionals and community agencies. In an area in which resources are as chronically scarce as protective services, it is important that these resources be used in the most effective way. Lack of communication between agencies involved in the provision of services to families of abused or neglected children can lead to feelings of frustration and anger among those involved. Workers in one agency may have unrealistic expectations concerning the services available at another agency, or may be unaware of available services. An interagency multidisciplinary team can provide a forum for the exchange of services information, and for the development of better relationships among agencies. Moreover, if services are coordinated, the risk of duplication of effort or working at cross purposes is diminished.

Multidisciplinary teams within organizations such as hospitals can make use of existing resources within the hospital in a more effective way. Besides encouraging a sharing of expertise among professionals, the use of teams in case management brings to bear more perspectives on cases, and can relieve the social worker or pediatrician of the burden of having to make difficult case decisions alone. The concentration of expertise and responsibility for diagnosis or management in a hospital-based multidisciplinary team may lead to better recognition and handling of cases.

Types of Multidisciplinary Teams and How They Work

Child abuse multidisciplinary teams can be roughly categorized according to their organizational locus. Many multidisciplinary teams operate under the auspices of hospitals. According to Ray E. Helfer, M.D., a pioneer in the development of the multidisciplinary approach, any hospital which sees more than 25 cases of abuse or neglect per year should have a well-defined child abuse multidisciplinary team.[2] Other multidisciplinary teams are not organizationally attached to any particular agency, but have members who represent different agencies.

Hospital-Based Programs

Although the treatment-oriented program at the University of Colorado Medical Center has provided a model for many other programs, including the Sinai Hospital program described below, most hospital multidisciplinary teams are not primarily organized for providing continuing direct treatment services. A 1973 survey of hospital programs dealing with child abuse and neglect showed that relatively few functioned as a treatment resource. Twenty-two of the 41 programs had a multidisciplinary team which engaged in evaluation, consultation, and crisis intervention; cases were referred to other agencies for long-term care.[3] In many hospitals, the multidisciplinary team physician serves as the reporting physician for other doctors who use the hospital.

One program which illustrates the way in which a hospital multidisciplinary team can serve as a treatment resource, providing intensive evaluative, medical, and psychotherapeutic care for abusive families, is the Child Abuse Project at Sinai Hospital in Baltimore.[4] The multidisciplinary team associated with this project is composed of 2 full-time paraprofessional community aides, a half-time nurse, a consulting pediatrician, a consulting psychiatrist, and a full-time social worker. An integral part of this team is the full-time secretary, who provides a variety of critically needed services and serves as a central point for all team communication and activity. The project is coordinated with the state's child protective service agency so that referrals are accepted only from its local departments. The team social worker is the project coordinator, as well as the primary therapist for family members. The community aides function as listeners and behavioral models to the abusive parents; they work to ameliorate environmental stresses facing parents and act as parent advocates to overcome service gaps. The team pediatrician is available for medical evaluations and to provide ongoing medical care for the children and other family members. The nurse's role complements that of the physician in seeing that family health needs will be met either within the scope of the program or by local community health resources. The psychiatrist provides ongoing consultation to the social worker, interviews each family, evaluates possible organic disorders which may contribute to parental violence, and is present at all weekly staff meetings. Evaluative data collected on the Sinai project demonstrate that families served by the program have benefitted substantially from the team's intervention. One factor in the success of the program has been the careful selection of staff members who are willing to become intensively involved with their clients and stay involved throughout the course of treatment.

Because of the legal status of the mandated child protective services agency and reporting requirements in most states, some agreement between the child abuse team and the agency is desirable. The inclusion of a representative of the mandated agency on a team is invaluable in coordinating the efforts of the team and the agency. The Boston Children's Hospital Medical Center's Trauma X Team, which is primarily oriented toward providing multidisciplinary case consultation, is an example of a hospital-based program which uses representatives from outside agencies. Four protective services agencies, including the state's mandated agency, are represented on the Team. Nevertheless, it is the hospital administration, specifically the Department of Patient Services, which has responsibility for the conduct of the Team. Other Team members are a pediatrician, a psychiatrist, a hospital social worker, a child development specialist, a psychologist, a nurse, a case data coordinator, and an attorney. The Trauma X Team is a consultative group available to any professional at the hospital faced with the task of handling a vulnerable child and his family. Consultation may include any one or all of the following: support; information; and assistance in assessment, treatment planning, and followup. The mechanism through which the consultative input is

provided is decided by the individual requesting assistance. Consultation can take place in a number of ways, including by telephone, chart review, participation in the interviewing of parents, or through the Team's weekly clinical conference. There is at least one Trauma X Team consultant on call at all times. Child abuse cases are handled by management teams consisting of a physician, a nurse, and a social worker. The consultant on call at the time of a case referral becomes the Designated Consultant from the Trauma X Team to the case management team, acts as a link between the two teams, and participates in the evaluation and assessment of the case. Although all the Trauma X Team consultants are on call on a rotating basis, each has, in addition, special duties related to his or her profession. While Team members are not involved in the direct provision of treatment services, their input into the management of child abuse cases fosters sensitive and humane handling of these cases, and exposes the professionals directly providing family services to the elements of good clinical management of child abuse and neglect.[5]

The Children's Protective Services Center in Honolulu illustrates a unique way of coordinating the hospital and social service agency. Under an agreement between the mandated agency, the Hawaii Department of Social Services and Housing, and the Kauikeolani Children's Hospital, the protective service unit is housed in the hospital. The protective service social work staff responds administratively to the public welfare agency and works cooperatively with the medical component at the hospital. The social work component continues to receive all referrals for protective services and is responsible for social service diagnosis and treatment. The medical component provides diagnosis and treatment in physical medicine for the child, and provides psychiatric and psychological diagnostic evaluations of child and family. All of the medical team members -- a pediatrician, a psychiatrist, and a psychologist -- serve as consultants to the social workers. These medical members, and the public welfare social work supervisor, meet weekly to provide diagnostic consultation on cases presented by social workers. The social worker has the final responsibility for deciding the course to follow in individual cases.[6]

The child abuse program at the Presbyterian-University of Pennsylvania Medical Center in Philadelphia illustrates a very different relationship between a hospital multidisciplinary team and the mandated child protective services agency. The program, which includes the disciplines of social work, public health nursing, pediatrics, and psychiatry, developed in an atmosphere in which hospital staff felt that the mandated agency was not providing its legally mandated services. An agreement with the agency was reached which allowed the hospital project to provide services to families of abused and neglected children whom the hospital reported. The mandated agency agreed not to pursue further investigation in these cases as long as the hospital project regularly reported the status of each family to a designated supervisor at the agency.[7]

Interagency Programs

Perhaps because of the extensive coverage given treatment-oriented, hospital-based multidisciplinary teams in the literature, there has been some confusion over what a multidisciplinary team is and can do. A multidisciplinary team does not have to be treatment oriented, nor need it be based in a medical center. Different communities, having very different protective services needs and resources, evolve child abuse teams designed to meet the unique problems which face them. Many community programs have been developed for such specific purposes as better reporting and interagency coordination.

In Boston, a city with several teaching hospitals and a number of social service agencies, a multidisciplinary program evolved out of frustration caused by poor interagency coordination. With so many organizations involved in child abuse and neglect treatment and intervention, there was an acute need for communication and coordination, and clarification of roles. Children's Advocates, Inc. had its beginnings in informal meetings between a hospital and the mandated child protection services agency. It has grown to include representatives of 23 agencies, all involved in direct services to children and their families. The coordination made possible by Children's Advocates has been a boon in the identification of abused children. Because there is a tendency for abusive parents to go "hospital shopping" to avoid recognition, a network for sharing information on these cases can help considerably in identifying them. Such a network now exists in Boston. Besides sharing information and expertise, members work on committees to develop community resources. There is an education committee which has developed a speakers bureau to talk about reporting. A resource committee has arranged an information and referral telephone service for lay people and professionals, and has sponsored a Parents Anonymous group. Other committees have been formed to deal with public relations, legal issues, and membership. This program illustrates how much can be done toward effectively mobilizing the community to deal with child abuse and neglect, without any involvement in direct service provision and without major expenditure.[8]

Some teams combine the function of interagency coordination with that of direct responsibility for case management and service delivery. The Ramsey County (Minnesota) Child Abuse Team is an example of this type of program. Here, team members who represent different agencies are involved directly in case management. Prior to the development of the Child Abuse Team, community intervention in child maltreatment was fragmented. Coordination among agencies was poor, and the Ramsey County Welfare Department, which is legally responsible for child protection, was ill-equipped to deal with the multiproblem families involved in child abuse and neglect.

In May, 1969, the Judge of the Juvenile Court urged that a program be developed to coordinate the work of medical, legal, and social agencies. This idea received the support of several area program directors and professionals. The St. Paul - Ramsey Mental Health

Center was chosen to organize the program. The Child Abuse Team includes representatives of all community agencies which are significantly involved in intervention and treatment of abusing parents and abused children. Agencies represented include the St. Paul Police Department; the Ramsey County Welfare Department; the Ramsey County Juvenile Court; the Departments of Pediatrics and Social Work at St. Paul - Ramsey Hospital; Children's Hospital; the Ramsey County Nursing Service; the Community Mental Health Center; and the Wilder Children's Placement Service.

Member agencies routinely utilize the team on all cases of confirmed abuse. Information on cases of abuse is shared by agencies and services are coordinated through the Team. Importantly, member agencies have not abrogated their respective roles and responsibilities: the police still investigate the circumstances of the abusive incident; the Welfare Department still provides investigation, assessment, and case management services; and the Mental Health Center is involved in psychological evaluations and therapy. The Team does not dictate the action of any professionals; it only discusses cases and makes recommendations. The team process consists of emergency staffings, which are called when a child appears to be in imminent danger; treatment planning staffings, held as soon as all the relevant information on a case is available; and implementation staffings, held at least quarterly by involved professionals when three or more agencies are involved in a case. Administrative policy commitments from all member agencies to involvement in the Team were found to be of crucial importance for its functioning. Equally important was the designation of a Team coordinator, the only funded position on the Team. Finally, it was found that role definitions of Team members had to be clear and mutually agreed upon. Because of the complexity of community coordination, the process requires significant ongoing efforts to run smoothly. Over seven years of operation, during which the Team has been involved in about 600 cases of child abuse and neglect, the benefits of Team operation have proved to be well worth the effort.[9]

Multidisciplinary teams can be valuable in special applications as well as in community organization and coordination or treatment. For example, in the Adams County (Colorado) School District, a "minimalist" multidisciplinary team operates to coordinate abuse and neglect cases among the district's pupils. The team, which was recommended by a special task force convened to develop solutions to poor reporting by school personnel and lack of coordination in handling cases, consists of a social worker and a nurse who have district-wide responsibility and act as a central clearinghouse for all incidents of abuse or neglect. The school principal and another school representative, usually the resident counselor, assist in the handling of cases in their school. Implementation of the program included panel presentations for school personnel. During the 1972-73 school year 24 cases were processed by the team. Most were handled without referral to other agencies. In several cases, seemingly insignificant incidents were reported that were matched later with similar occurrences involving a sibling in another school. Thus, the program's record

system provided data whose relevance might otherwise have been overlooked. Even when limited in scale and in scope, multidisciplinary teams can make a valuable contribution in the detection and handling of child abuse and neglect cases.[10]

State-Mandated Multidisciplinary Teams

Several states have either mandatory or permissive legislation for the establishment of multidisciplinary teams. The Colorado law[11] encourages the creation of child protection teams in each county or contiguous group of counties. In counties in which 50 or more incidents of child abuse are reported in one year, the child protection teams must be established the following year. The teams, which are under the direction of the county welfare departments and include representatives of local law enforcement agencies and the juvenile court, review case materials, make recommendations to the county welfare department on individual cases, and make reports to the state central registry.

Michigan's law[12] directs the state-mandated child protective service agency to provide "multidisciplinary services...through the establishment of regionally based or strategically located teams." The teams provide services "such as those of a pediatrician, psychologist, psychiatrist, public health nurse, social worker, or attorney." Missouri requires the use of multidisciplinary services "whenever possible," both in investigating cases and providing treatment services.[13] California has authorized the establishment of pilot multidisciplinary teams in three counties,[14] and Pennsylvania law requires that each child protective service agency in the state make a multidisciplinary team available.[15] The Virginia law[16] establishing multidisciplinary teams is explicit in spelling out the team composition and functions:

> "The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based multi-discipline teams which shall include, where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children, coordinating medical, social, and legal services for the children and their families, helping to develop innovative programs for detection and prevention of child abuse, promoting community concern and action in the area of child abuse and neglect, and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect. The local department shall also coordinate its efforts in the provision of these services for abused and neglected children with the judge and staff of the court."

The codification of multidisciplinary teams in state law reflects the growing consensus in the child abuse and neglect literature on the necessity of a multidisciplinary approach to deal with abuse and neglect.

Child abuse multidisciplinary teams are now operating on many Federal military bases. Army regulations provide for the establishment of a Child Protection Committee (CPC) on every base; the Air Force has issued similar guidelines. The CPCs usually include pediatricians, social workers, psychiatrists, nurses, Red Cross workers, military family service or Army Community Service workers, chaplains, lawyers, military police, and unit commanders. Often, representatives from local civilian child protection agencies sit on the military committees in liaison, consulting, and support roles. The military has developed the team approach because there are no military welfare agencies similar to those in civilian communities, and because the legal base for child protective services in the military is limited.[17]

Conclusions

Multidisciplinary teams represent a major step in the direction of more humane and effective child protection, and it appears that they will continue to proliferate. The multidisciplinary approach is consonant with the best thinking in the child protection literature. Eli Newberger, M.D., and others have noted that the multidisciplinary approach is better suited to the preservation of the family than earlier efforts. Different agencies and professionals working in relative isolation from one another can do more harm than good and break up the family. As Newberger points out:

> "we now know that with the right kind of interdisciplinary cooperation, families can be kept together and made to be safer, more nurturant contexts in which children who have suffered abuse can grow. Professional energies will be invested more in the direction of making families stronger than in simply assuring that children's risk of reinjury is reduced."[18]

Multidisciplinary teams can help eliminate, or at least reduce, many institutional and other barriers to effective action. Among the barriers noted in the literature are lack of understanding by the members of one profession of the objectives, standards, conceptual bases, and ethics of the others; lack of effective communication; confusion over roles and responsibilities; interagency competition; mutual distrust; and institutional relationships which limit interprofessional contact.[19]

The results of systematic evaluation of multidisciplinary team efforts are encouraging. The Sinai Hospital team included a research component whose conclusion was that "the overall results of team intervention, which have been substantiated both by observable changes

in family functioning and by ongoing systematic research, have been gratifying."[20] Evaluation of the handling of child abuse cases at Boston Children's Hospital Medical Center showed a reduction in the cost of medical services and in the risk of reinjury subsequent to diagnosis of child maltreatment after the institution of the Trauma X Team.[21]

A recently conducted survey of 14 multidisciplinary teams revealed a number of problems and advantages in their operation. Two of the teams reported no problems, and six indicated that their problems were minor. On eight teams, intellectual conflict between members sometimes made a consensus difficult to reach. This problem, however, appears to diminish over time. Six teams identified the problem of territoriality or "turfism." Problems caused by personal conflicts were reported in six teams, but these were resolved in the group process. Four teams reported difficulty in developing treatment plans which realistically reflected the available resources, and four reported that confidentiality of client records was problematic. Problems related to scheduling team meetings and the geographic location of meetings were also reported.

The advantages of multidisciplinary operation, however, seemed to outweigh the disadvantages, which were generally characterized as minor. None of the teams reported that they had not met their objectives. Some team advantages have already been noted: the contribution of several different professional perspectives; the sharing of responsibility for difficult cases; the broadening of perspectives brought about by exposure to other disciplines; and the improvement in the quality of case management decisions. Interagency multidisciplinary teams studied tended to facilitate cooperation between potentially competitive service providers. Moreover, the cost efficiency of these teams was termed "impressive."[22]

Besides providing a better and less expensive means of intervening in the cycle of child abuse and neglect, multidisciplinary teams offer several advantages accruing from their concentration of expertise. Multidisciplinary team members are well-suited to engage in community awareness activities such as speaking before groups, running workshops, and providing training for other involved personnel. They can become the focal point in the community for child advocacy, and for the development of additional resources.

Multidisciplinary teams may well represent a major part of the future of child protective services. Dr. Helfer maintains that "we can no longer afford the archaic system of maintaining county-governed child protection services and expect to make progress in the area of child abuse and neglect."[23] He proposes the organization of child protective services on a regional basis, with state-administered multidisciplinary programs providing acute care, long-term therapeutic intervention, education, evaluation, and research.

FOOTNOTES

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12. Mich. Comp. Laws, s722.629 (1) (Supp. 1976).

13. Mo. Rev. Stats. s210.145 (6) (Supp. 1976).

14. Calif. Welf. and Inst. Code s18951(d), 18960(f) (Supp. 1976).

15. Penna. Stat. Ann. tit. 11, s2216(d) (Supp. 1976).

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20. Barnes, ibid.

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Appendix A

Child Abuse and Neglect Programs Which Use

A Multidisciplinary Approach

(Arranged by Federal Region)

The information for this Appendix comes from Child Abuse and Neglect Programs, The National Center on Child Abuse and Neglect (DHEW), March 1978. Available for purchase from:

The National Technical Information Service (NTIS)
5285 Port Royal Road
Springfield, VA 22161

Purchase Information:

PB-277 824 NTIS Price: $15.50
CHILD ABUSE AND NEGLECT PROGRAMS
March 1978, 529 pp.

CP-00067
Boston Hospital for Women, Mass.
221 Longwood Ave.
Boston, MA 02115
Team for the Prevention of Family Breakdown.
A. Groves.
Oct 74.

Services: Part of this program is concerned with child abuse and neglect. Social work counseling, health counseling, family planning, and medical care are offered directly to parents; weekly follow-ups are conducted by social workers and nurses. Medical care is directly available to children. Other services are made available by referral, including homemaking services, day care, foster care, and welfare assistance. Daily to monthly follow-ups are made by social workers, visiting nurses, and visiting homemakers.
Clientele: Individual parents served by the program come from mixed-income, urban and inner-city areas. Twenty-four mothers were treated in the last fiscal year.
Staffing: All the staff are employed by the hospital and include primarily child welfare personnel, nurses, and psychiatric social workers. Psychiatrists, pediatricians, and homemakers also render services when needed.
Organization: The Boston Hospital for Women houses and conducts the program.
Coordination: The team receives its cases from hospital staff. Case reports are made to social services authorities.
Funding: Program activities are supported financially by the hospital.

CP-00013
Children's Hospital Medical Center, Boston, Mass.
300 Longwood Ave.
Boston, MA 02115
Children's Hospital Trauma X Team.
A. Serotkin, and J. Hyde.
Sep 70.

Services: The Trauma Team, devoted entirely to child abuse and neglect problems, provides social work counseling and medical care for families. Parent Anonymous, various types of counseling and therapy, homemaking services, and welfare services are offered through referrals. The children are furnished with medical care, individual therapy, and specialized therapy. Day care, play therapy, therapeutic day care, foster care, foster and residential care are supplied through referrals. The program also provides medical evaluations, psychiatric evaluations, and discharge planning. Follow-up is maintained through telephone and personal contact, and conferences at various monthly intervals.
Clientele: The program clientele are comprised of approximately 80 percent families and 20 percent children. They are from suburban, urban and inner-city areas and found in all income levels.
Staffing: The team includes a lawyer, nurses, psychiatrists, pediatricians, psychiatric social workers, psychologists, administrators, and social workers.
Organization: The administering agency is private and nonprofit.
Coordination: Staff are from the hospital's Family Development Study, Massachusetts Society for Prevention of Cruelty to Children, and the State Division of Family and Children's Services. Case referrals come from private physicians and social service agencies, hospitals, schools, and concerned individuals. The program shares medical information with other local hospitals, including Boston City Hospital, New England Medical Center, and Massachusetts General Hospital. The program also shares case information with other local groups and agencies such as Neighbor Health Centers, Families Service Agencies, Boston Children's Services, and others. The team reports individual cases to social services and the state central registry.
Funding: In the last fiscal year the hospital provided 85 percent of the program's funds. The remainder was provided directly through federal sources.

CP-00048
New Hampshire State Div. of Welfare, Keene, Keene District.
116 Main St.
Keene, NH 03431
Child Abuse Project.
S. M. Holden.

Services: Lay therapy, social work counseling, pediatric care, home economics training, and psychological and psychiatric counseling are provided for families.
Staffing: A social worker is on the project staff. A pediatrician, a psychologist, a psychiatrist, and a teacher volunteer their time. A parent aide has been added.
Organization: The administering agency is a county office of the State Division of Welfare which is part of the State Department of Health and Welfare.
Coordination: The mental health personnel serving the project come from Monadnock Area Mental Health, the pediatrician comes from Keene Clinic, and a professor of home economics comes from Keene State College. Information concerning procedures of this multidisciplinary team is shared with the Task Force on Child Abuse.

CP-00053
Family Service Society of Pawtucket, R.I.
33 Summer St.
Pawtucket, RI 02860
Police Crises Teams.
J. Carr, and M. Penlini.
Jan 74.

Services: Social work counseling, couples counseling, family counseling, individual therapy, and health counseling for parents are available directly. Group therapy, individual therapy, health counseling, welfare assistance, and family planning aid are offered through referrals. Individual therapy to children is available directly or through referrals. The training of police officers in other communities is contemplated in the upcoming year.
Clientele: The clientele, who are primarily low-income, are drawn from suburban, urban, and inner-city areas. Individual children and families constitute 10 and 90 percent, respectively, of the total client profile.
Staffing: Family counselors, psychiatric social workers, and police officers comprise the program staff.
Organization: The program is operated by a private, nonprofit organization which is focused on mental health. Supervision of the project is carried out by a board of directors. Major operational changes which have been made include the extension of services to 3 more communities.
Funding: Program income consists of 90 percent federal funds distributed through the state, 5 percent state funds, and 5 percent private foundation grants.

CP-01709
Boston Dept. of Health and Hospitals, Mass.
818 Harrison Ave.
Boston, MA 02118
Boston City Hospital Child Abuse Team.
A. McDonald.
Sep 70.

Services: The program is primarily concerned with child abuse and neglect. Social work counseling, health counseling, family planning assistance, and medical care are provided for families. Social work counseling, group therapy, Parents Anonymous, couples counseling, family counseling, individual therapy, child management classes, welfare services, family planning assistance, and residential care are available through referrals. The children are provided with medical care, play therapy, individual therapy, and specialized therapy. Children are referred for day care, therapeutic day care, foster care, and residential care. Quarterly follow-up is maintained through return visits to the clinic and contacts with other community agencies involved with the families.
Clientele: The program usually serves low-income families from urban and inner-city areas.
Staffing: Team members include child welfare personnel, lawyers, nurses, pediatricians, social workers, and a data coordinator. All team members are employed by the Department of Health and Hospitals in other programs and are volunteers with the Child Abuse Team.
Organization: Evaluation is performed informally through peer review and interagency dialogs.
Coordination: Clients are referred from a wide variety of sources including some neighborhood health centers. Cases are reported to the judicial branch, juvenile services, and social welfare services.

CP-00082
Newark Police Department, N.J.
20 Mt. Pleasant Ave.
Newark, NJ 07104
Youth Aid Bureau.
G. P. Hemmer.

Services: Child abuse and neglect are a part of the program scope. The bureau directly provides social work counseling. Referrals are made to the New Jersey Division of Youth and Family Services for family counseling and individual therapy for children. A police team approach in child abuse and neglect cases in conjunction with other agencies is anticipated.
Clientele: Individual children and individual parents served by the program mostly come from the inner city of Newark. There were 76 cases in the last fiscal year.
Staffing: Criminologists, family counselors, psychologists, and social workers staff the bureau--some on a part-time basis.
Organization: The Police Department is directly supervised by the Newark City government.
Coordination: Referrals to the bureau come from social service agencies, schools, the police, relatives, and neighbors. Case reports are made to the central registry operated by the Division of Youth and Family Services and information is shared with the courts and the Essex County Prosecutor.
Funding: Approximately 95 percent of the program's financing came from the city and 5 percent from state-administered federal funds in the last fiscal year.

CP-00087
Visiting Homemaker Service of Morris County, Morristown, N.J.
62 Elm St.
Morristown, NJ 07960
Community Homemaker Health Aide Program.
C. Gunther, and F. M. Strand.
Apr 75.

Services: Part of the program deals with child abuse and neglect. The main focus of the program is provision of home health assistance. Welfare assistance and mother substitutes are also provided. Social work and health counseling, family planning assistance, medical care, day care, individual therapy, foster care, and specialized therapy for children are also available by referral. Follow-up is done by a referral agency.
Clientele: Families served by the program are considered low-income by federal standards and come from suburban areas.
Staffing: The staff consists of 5 homemaker specialists, a family counselor, and a nurse.
Organization: The program is conducted by a private, nonprofit agency. The program is self-evaluated through team conferences, statistical reports, and periodic meetings with referral agencies and the State Division of Youth and Family Services.
Coordination: Families are referred to the program by the New Jersey Division of Youth and Family Services (DYFS), the Family Service Association, other social service agencies, and hospitals. Case reports are made to the DYFS central registry and juvenile and social welfare services. The program exchanges information with the above agencies and the Morris County Welfare Board.
Funding: During the last fiscal year, approximately 75 percent of the program income was from state-administered federal funds, 20 percent from county funds, and 5 percent from state funds.

CP-00148
Long Island Jewish-Hillside Medical Center, New Hyde Park, N.Y.
New Hyde Park, NY 11040
Child Protection Team.
P. Lanzkowsky, and B. N. Bogard.
Jan 74.

Services: The program's primary focus is child abuse and neglect. Children are directly administered medical care and specialized therapy; parents receive family counseling, medical care, family planning aid, health counseling, and individual therapy from the team. Follow-up is carried out by social workers monthly and by the Visiting Nurse Service weekly. A day care center is contemplated.
Clientele: Suburban and urban-dwelling children and their parents are treated individually by the team. Fifty percent of the clients are parents and 50 percent are children. In the last fiscal year 16 parents were treated, 8 parents were followed up, 8 children were treated, 4 children were followed up.
Staffing: The team is composed of a physician, a pediatrician, a nurse, a psychiatrist, and a social worker.
Organization: This is a private, nonprofit program.
Coordination: Clients are brought to the attention of the team by private physicians, hospitals, parents, and by clients themselves. All cases are reported to social and welfare services authorities.
Funding: Approximately 40 percent of the team's financing was met by the hospital, 40 percent was obtained from the city, and 20 percent was county funding during the last fiscal year.

CP-00160
Onondaga County Child Abuse Coordinating Program, Syracuse, N.Y.
1654 W. Onondaga St.
Syracuse, NY 13204
Onondaga County Child Abuse Coordinating Program.
D. Meier.
Jul 72.

Services: Most of the program scope encompasses child abuse. Services in the areas of identification, prevention, treatment, and follow-up are available. Social work counseling is furnished directly to parents, with a wide range of human, social, health, and welfare services offered on a contractual basis and through referrals; improvements are anticipated for parent aide services. A wide variety of child health and child care services are offered to children on a contractual basis or through referrals. Crisis day care and public health nursing have been added to the program recently. It is expected that the sexual abuse and crisis day care component will be strengthened. Follow-up is maintained through team meetings conducted on at least a biweekly basis, quarterly updates of case records of nonactive cases, and phone and letter contact as needed. The main purpose of the program is to coordinate diagnostic and rehabilitative services to parents suspected of child abuse.
Clientele: Services to families are emphasized. During the last fiscal year, identification, prevention, treatment, and follow-up services were provided to 373 individual children and to 161 families. Clients are drawn from low-income, inner-city areas.
Staffing: The program relies extensively on community service coordinators. Since its inception, the staff has increased from 2 to 6 persons; another addition to the staff may be made in the future.
Organization: The administering organization is governed by the Onondaga County Department of Social Services and by Catholic Charities. The program is evaluated through analysis of statistical data by the Family Court Executive and by a research aide employed by the program.
Coordination: Medical authorities, social service agencies, schools, concerned individuals, and victims are the major referral sources. Case information is shared with all referral agencies.
Funding: The county provides most of the program's funding. The program anticipates a contractual arrangement whereby approximately 20 percent of the income will come from the Community Foundation of the United Way and Catholic Charities.

CP-00191
Tompkins County Dept. of Social Services, Ithaca, N.Y.
108 E. Green St.
Ithaca, NY 14850
Child Protective Services Unit.
R. J. Wagner, and M. V. Beggs.
Sep 73.

Services: Most of the program's scope encompasses child abuse and neglect. Social work counseling, couples counseling, medical care, residential care, and employment assistance are offered directly to parents, with a wide range of human, social, health, and welfare services obtainable through referrals or on a contractual basis. Children receive day care and foster care services directly, with a wide range of child care and child health services furnished through referrals or on a contractual basis.
Clientele: Program services focus on individual children.
Organization: The administering organization is governed by the Tompkins County Government. A team of professional consultants meets with staff every other week to evaluate and review cases.
Coordination: Medical and legal authorities, private social service agencies, schools, concerned individuals, and victims are the major referral sources. Cases are reported by name to social services and to a central registry maintained by the New York State Department of Social Welfare.

CP-01736
George Junior Republic, Freeville, N.Y.
Freeville, NY 13068
George Junior Republic.
F. C. Spero.

Services: Child abuse and neglect constitute part of the program scope. The services available directly to children include individual therapy and residential care.
Clientele: The children who are served by the program come from mixed-income urban and suburban areas.
Staffing: Child welfare personnel, dentists, doctors, nurses, nutritionists, psychologists, social workers, and teachers comprise the program staff. An in-house team consisting of child care workers, teachers, and vocational instructors evaluates the treatment program under the coordination of a social worker.
Organization: The program is governed by a board of directors.
Coordination: Cases are referred to the program by government social service agencies, schools, courts, parents, or guardians.
Funding: Program income consists of funds from the state and foundations, personal donations, and fees from individual clients.

CP-00217
Anne Arundel County Dept. of Social Services, Annapolis, Md.
Calvert St.
Arundel Center
Annapolis, MD 21404
Multidisciplinary Committee on Child and Sexual Abuse.
A. L. Gazaway.
Oct 73.

Services: Part of the scope of this program is concerned with child abuse and neglect. The program offers social work counseling, family counseling, individual therapy, homemaking services, housing assistance, family planning assistance, medical care, and residential care directly to families. Services offered directly to children include day care, medical care, individual therapy, foster care, and residential care. Referral supplies lay therapy, group therapy, couples counseling, health counseling, child management classes, employment assistance and several of the direct services for families and specialized therapy and residential care for children.
Clientele: Families from rural and inner-city, mixed-income areas are usually served by the program.
Staffing: The staff consists of social workers.
Organization: The organization is supervised by the State Department of Social Services. The program is evaluated by casework staff, administrative staff, and committee members.
Coordination: Sources of referrals are medical authorities, private social service agencies, schools, legal authorities, parents, other concerned individuals, and clients. Cases are reported by name to the police or the judiciary and to the state central registry maintained by the Department of Human Services. Program staff is shared with the Health Department, the Board of Education, private social service agencies, and hospitals, including the Naval Hospital and the Kimbrough Army Hospital.
Funding: Funds are allocated to the program by the State Department of Social Services.

CP-00248
Washington County Dept. of Social Services, Hagerstown, Md.
112 W. Baltimore St.
Hagerstown, MD 21740
Child Protective Services.
F. J. Connolly, and G. D. Sencindiver.
Jul 66.

Services: The program scope is concerned with child abuse and neglect. Services offered directly in families include social work counseling, homemaking services, welfare assistance, family planning assistance, and medical care. Residential care for families is purchased, and they are referred for many of these services and for couples counseling, family counseling, individual therapy, health counseling, employment assistance, and housing assistance. Children are directly provided with day care, medical care, and foster care. Residential care for children is purchased, and they are referred for day care, medical care, individual therapy, and specialized therapy. There are monthly home visits, office visits, and telephone contacts for follow-up.
Clientele: The client profile generally consists of 50 percent individual children and 50 percent individual parents. They are primarily from rural, mixed-income areas.
Staffing: The staff consists of child welfare personnel, homemaker specialists, and social workers. The establishment of a multidisciplinary team is planned.
Organization: The organization is supervised by the Maryland Social Services Administration. The program is evaluated with field supervisory visits and case readings by that agency.
Coordination: Sources of referrals are medical authorities, private social service agencies, schools, law enforcement agencies, parents, other concerned individuals, and clients. Cases are reported by name to legal authorities, juvenile services, health departments, and to the state central registry maintained by the Maryland Social Service Administration. Some staff members are shared with Single Parent Service and Family and Children Services.
Funding: In the last fiscal year, the program was supported by state funds, state-administered federal funds, and county funds.

CP-00272
Children's Hospital, Philadelphia, Pa.
34th and Civic Center Blvd.
Philadelphia, PA 19104
Suspected Child Abuse-Neglect Team.
P. MacRae.
Jun 73.

Services: Part of the program deals with child abuse and neglect. The program encompasses the areas of identification, prevention, treatment, and follow-up. Parents receive social work counseling, and medical care directly from the program, while parent aides are available on a contractual basis. Comprehensive special, social, health, and specialized therapy are provided directly to children, with comprehensive child care and child health services obtainable through referrals.
Clientele: Individual children are the focus of the program. During the last fiscal year, 136 individual child abuse victims were identified, 41 received prevention services, and 177 received both treatment and follow-up services. Clients are drawn from low-income, rural, suburban, urban, and inner-city environments. The inclusion of borderline families is anticipated.
Staffing: Social workers and a coordinator are employed on a full-time basis. Nurses and pediatricians are also available. A psychiatrist is shared with the Philadelphia Child Guidance Clinic.
Organization: The Team is maintained by a private, nonprofit organization.
Coordination: The Children's Hospital is the major referral source. Cases are reported by name to the social services. Data is shared with the Suspected Child Abuse Center.
Funding: The program is entirely funded by the hospital.

CP-00302
Presbyterian-Univ. of Pennsylvania Medical Center, Philadelphia.
51 N. 39th St.
Philadelphia, PA 19104
Outreach Supportive Services.
C. Ballard.

Services: The service works primarily as a coordinating service for the Center's Child Abuse Team. The Team identifies cases, provides 24-hour coverage, home visiting services and other direct services to families. Outreach Services coordinates community and hospital services and, using a social-learning model theory, develops treatment plans.

CP-00304
Saint Christopher's Hospital for Children, Philadelphia, Pa.
2600 N. Lawrence St.
Philadelphia, PA 19133
Family Resources Center (National Demonstration Center for Child Abuse and Neglect, Philadelphia Area).
V. Vaughan, and O. R. Childress.
Jan 75.

Services: The program is focused entirely on child abuse and neglect. Identification, prevention, treatment, and follow-up services are provided. Social work counseling, lay therapy, couples counseling, family counseling, individual therapy, child management classes, housing assistance, employment assistance, welfare assistance, and educational services are offered directly to parents by the program. Health services are available through referrals. Comprehensive child care and child health services are available through referrals.
Clientele: Individual children, individual parents, and families account for 5 percent, 70 percent, and 25 percent of the total clientele, respectively. Low-income, urban and inner-city residents form the majority of clients served.

Staffing: The program utilizes lay therapists, pediatricians, psychiatrists, social workers, and training specialists.
Organization: The Center is administered by a private, nonprofit medical facility. Program evaluation is accomplished through casework supervision, team conferences, patient input and management consultation. Both the staff and clients are involved in on-going program evaluation.
Coordination: Medical authorities, private social service agencies, schools, concerned individuals, and victims are the primary referral sources. Cases are reported by name to the social service agencies. Information is shared with interested state and local social service and educational organizations.
Funding: Income was provided entirely from federal sources during the last fiscal year.

CP-01743
Kimbrough Army Hospital, Ft. Meade, Md.
Ft. Meade, MD 20755
Child Protection and Case Management Team.
D. A. Plymyer.
Feb 76.

Services: Most of the program scope focuses on child abuse and neglect. Direct services to parents include social work counseling, couples counseling, family counseling, individual therapy, family planning assistance, and medical care services. They are referred to other programs for group therapy, Parent's Anonymous, couples counseling, family counseling, individual therapy, homemaking, health counseling, housing assistance, and welfare assistance. Couples counseling, family counseling, individual therapy, and residential care services are purchased for parents from other programs. Children receive medical care services directly, and play therapy, specialized therapy, foster care, and residential care services are purchased for children from other programs. Follow-up is maintained through a quarterly review of medical records and through twice monthly staff meetings. The addition of a parent aide service is anticipated.
Clientele: Military personnel and their families are served. Individual children, individual parents, and families account for approximately 20, 60, and 20 percent of the total clientele, respectively. Clients are drawn from mixed-income rural, suburban, urban, and inner-city areas.
Staffing: The program staff consists of lawyers, nurses, pediatricians, psychiatric social workers, and social workers.
Organization: A case management summary on each established case of abuse or neglect is submitted to the Army Health Services Command at Ft. Sam Houston, Tex., for evaluation.
Coordination: Hospitals, government social service agencies, schools, law enforcement agencies, parents, relatives outside the immediate family, and neighbors are the major referral sources. Cases are reported by name to the legal authorities, social services, U.S. Army Health Services Commands, and to a central re-

tion is carried on via administrative supervision, peer supervision, and utilization of a team approach. External evaluation consists of contract accountability with the New York City Department of Social Services (DSS) and Nassau County DSS.
Coordination: Statistical information is shared with the Child Welfare Information System, and Brooklyn Catholic Charities, Child Care Division. Case referrals come from social service agencies, courts, and siblings. Cases are reported by name to legal authorities and juvenile services, by name and code to social service authorities, and by gross numbers to health departments.
Funding: In the last fiscal year 81 percent of the program's income came from city funds, 13 percent from county funds, and 6 percent from personal donations.

CP-00457
Pinellas County Juvenile Welfare Board, St. Petersburg, Fla.
3455 First Ave. S.
St. Petersburg, FL 33711
Parent and Child Effective Relations.
C. G. Bennett, and R. L. Edwards.
May 74.

Services: In working with the interactions between parents and children the program serves abusive and neglectful parents and their children in addition to other families. The program provides a Parents Anonymous group, volunteer parent aides, a hospital trauma team, maternity ward consultation, child management classes, a legal intern program, staff training, education programs, and other early identification and prevention services. Babysitting is also provided for the families. Follow-up is completed through monthly behavioral record check lists through a cross record check with community. Other services are provided through referral.
Clientele: Clientele are from mixed income levels and usually live in urban or suburban areas, of the program is training staff members of other public agencies.
Staffing: The program staff consists of program evaluators, psychiatric social workers, and social workers.
Organization: The administering organization is governed by the Pinellas County Board of Commissioners. The evaluation is performed by Berkeley Planning Associates and through internal analyses. The program is one of the federal government's Demonstration Child Abuse and Neglect Programs.
Coordination: Information is exchanged concerning cases with the Florida Department of Health and Rehabilitative Services and other local social service agencies and health agencies. General information concerning child abuse and neglect is provided to other public organizations. Also, one of the major parts of the program is training staff members of other public agencies. Physicians, social service agencies, schools, parents, and self-referrals are the program's primary sources of referral. Cases are reported individually to the Florida Department of Health and Rehabilitative Services. Cases are also reported by code to Berkeley Planning Associates and only in gross numbers to the Office of Child Development.
Funding: In the last fiscal year the program was supported entirely through federal funds.

CP-00475
Clayton County Protective Services Team, Jonesboro, Ga.; Clayton Mental Health Center, Jonesboro, Ga.
213-D Arrowhead Blvd.
Jonesboro, GA 30238
Children's Program.
R. Coody.

Services: Part of the program is focused on child abuse and neglect. The program provides social work counseling, group therapy, couples counseling, family counseling, individual therapy, child management classes, and psychological and psychiatric diagnostic evaluations for families. Homemaking services, health counseling, welfare services, family planning assistance, medical care, and residential care are provided through referrals. Play therapy and individual therapy are furnished for children. Medical care, specialized therapy, foster care, and residential care are supplied for children through referral.
Clientele: In the last fiscal year, 50 children and 10 families from all income levels were treated. Clients are usually from rural or suburban areas.
Staffing: The program is staffed with psychiatric social workers, psychiatrists, psychologists, and teachers.
Organization: The program is supervised by the Division of Mental Health of the Department of Human Resources.
Coordination: Case information is exchanged with the Clayton County Department of Family and Children Services, the Juvenile Court, and the Protective Services Team. A teacher-therapist is shared with the Clayton County Board of Education. Medical authorities, public social service agencies, schools, courts, clients, and other private individuals refer cases to the program. Cases are reported to social welfare services.

Funding: In the last fiscal year 30 percent of program's income was provided by the state, 10 percent through state-administered federal funds, and 60 percent through county funds.

CP-00574
Alamance County Dept. of Social Services, Burlington, N.C.
1950 Martin St.
Burlington, NC 27215
Protective Services Unit.
A. L. Burton, and R. M. Whiteneck.
Sep 70.

Services: Part of the program deals with child abuse and neglect. Identification, prevention, treatment, and follow-up services are delivered. Social work counseling, lay therapy, couples counseling, family counseling, individual therapy, homemaking services, family planning assistance, medical care, and welfare services are offered directly to parents, with health counseling and child management classes available contractually. Children receive medical care, play therapy, individual therapy, foster care, and residential care directly, with day care and therapeutic day care furnished on a contractual basis. Specialized therapy is provided through referrals. Follow-up is maintained via biweekly individual contracts with parents and children, monthly correspondence, and monthly collateral contacts with referral agencies. The development of a Parents Anonymous group is anticipated.
Clientele: Individual children, individual parents, and families are served. In the last fiscal year, identification, prevention, treatment, and follow-up services were provided to 530, 10, 265, and 265 individual children, respectively; 400, 10, 130, and 130 individual parents, respectively; and to 200, 10, 105, and 105 families, respectively. Clients are drawn from mixed-income, rural and urban areas.
Staffing: Child welfare personnel serve the program.
Organization: Goal setting is utilized to ascertain program effectiveness in individual cases.
Coordination: Medical and legal authorities, schools, concerned individuals, and victims are the major referral sources. Cases are reported by name to the legal authorities and to a central registry maintained by the North Carolina Department of Human Resources. Relevant information is also shared with the Alamance-Caswell Mental Health Center and with the Mal-Treatment Syndrome Team of the North Carolina Memorial Hospital. A social worker and homemakers are shared with the Alamance-Caswell Mental Health Center.
Funding: The county provides the bulk of the program's finances.

CP-00722
Child Advocate Association, Chicago, Ill.
19 S. La Salle St. Rm. 401
Chicago, IL 60603
Child Advocate Association.
T. Hanrahan.
Feb 75.

Services: Most of the program scope encompasses child abuse and neglect. Follow-up services are emphasized. The program provides legal intervention on behalf of children in relation to those services and institutions that impinge on their lives. Legal representation services are offered directly to children. The program aims to establish hospital-based, interdisciplinary, interagency child abuse teams at key county hospitals; to develop a pool of volunteer attorneys to provide legal assistance to abused children; to provide legal and social work consultation to allied professions; to develop treatment resources for families who abuse their children; and to encourage increased awareness and skill in handling child abuse on the part of professionals and the public. Follow-up is maintained through bimonthly case conferences and court reports.
Clientele: Program services focus on individual children. Clients are drawn from urban areas.
Staffing: The program staff consists of lawyers and social workers.
Organization: The Association is a private, nonprofit child advocacy organization.
Coordination: Hospitals and social service agencies are the major referral sources.
Funding: In the last fiscal year, primary funding of the program was provided by the Illinois Law Enforcement Commission. Additional income consisted of foundation grants and personal donations.

CP-00988
Jefferson County Children Services Board, Steubenville, Ohio. Div. of Protective Service.
240 John Scott Hwy.
Steubenville, OH 43952
Protective Services for Children.
W. Dinello, and M. A. Curfman.
Feb 88.

Services: The program scope is primarily focused on child abuse and neglect. Social work, marriage, family counseling, parent aides, group and individual therapy, homemaking services, Parents Anonymous, residential care, and assistance in employment and housing are offered to parents directly; welfare assistance and medical care are available through purchase; and group and individual therapy, marriage and family counseling, child management classes, health counseling, medical and residential care, and employment, housing, welfare and family planning assistance are available through referrals. Day, residential, and foster care and individual therapy are offered to children directly; medical care, play therapy, and specialized therapy are available through referrals. Follow-up by investigation and counseling is provided as needed.
Clientele: In the last fiscal year, identification, treatment, and follow-up services were provided for 539 individual children and 430 families from low-, middle-, and upper-income levels and various locales.
Staffing: Child welfare personnel, physicians, and caseworkers comprise the program staff. Development of a team approach to combat child abuse and neglect is anticipated; teams will consist of law officer, physician, and staff member.
Organization: This is a county agency under the supervision of the Ohio Department of Public Welfare. The program is evaluated in-house.
Coordination: Medical authorities, social service agencies, schools, law enforcement agencies, courts, abuse victims, and other concerned individuals refer cases to the program. Cases are reported by name to the police and judiciary, and to juvenile services, welfare services authorities, health departments, and a state central registry. Relevant information is shared with the Jefferson County Welfare Department.
Funding: Monetary support is received from state, state-controlled federal county, and city sources.

CP-00992
Miami County Children Services Board, Troy, Ohio.
201 W. Main St.
Troy, OH 45373
Child Abuse Review Team.
R. S. Painter.
Sep 75.

Services: The program focuses entirely on child abuse. Social work counseling, family counseling, and residential care are offered to parents directly; couples counseling, individual therapy, and welfare and family planning assistance are available through referrals. For children, foster and residential care are offered directly.
Clientele: Families constitute the entire client profile; they come primarily from rural areas.
Staffing: Child welfare personnel comprise the staff.
Organization: The program is new; evaluation methods and procedures are being developed.
Coordination: Medical authorities, government social service agencies, schools, law enforcement agencies, courts, abuse victims, and other concerned individuals refer cases to the program. Cases are reported by name to the police and judiciary, and to social and welfare services and a state central registry.

CP-01005
Stark County Dept. of Welfare, Canton, Ohio. Div. of Social Services.
209 W. Tuscarawas St.
Canton, OH 44702
Child Protective Services.
L. Burd, and C. E. Calhoun.
Jun 69.

Services: The program scope is primarily focused on child abuse and neglect. Social work counseling, lay therapy, marriage and family counseling, individual therapy, health counseling, employment, housing, and welfare assistance, and family planning are offered to parents directly; individual therapy, homemaking services, and medical and residential care are available by purchase; and group therapy, Parents Anonymous, marriage and family counseling, health counseling, child management classes, and family planning assistance are available by referral. For children, foster and residential care are offered directly; day care, therapeutic day care, medical care, specialized therapy, and residential care are available by purchase; and play, individual and specialized therapy are available by referral. Follow-up is made by worker or volunteer visits to the home 2-3 months after the case is closed, with an average contact of twice each month.
Clientele: In the last fiscal year, 1,011 families were served by the program; they came from various locales and mixed-income levels.
Staffing: Child welfare personnel comprise the staff. Future plans include inclusion of an expanded team approach.
Organization: The program is under the supervision of the Ohio Department of Public Welfare.
Coordination: Medical authorities, social service agencies, schools, law enforcement agencies, courts, prospective clients, and other concerned individuals refer cases to the program. Cases are reported to the state central registry maintained by the Ohio Department of Welfare. Protective day care is purchased from a child development center and homemaker service is purchased from a family counseling center.
Funding: Monetary support comes from state, state-administered federal, and county funds.

CP-01798
American Red Cross, Chicago, Ill.
43 E. Ohio St.
Chicago, IL 60611
Parent Aides -- Volunteers in Support of Visiting Nurses Association -- Neglected Children.
J. Oes Landis.
Jul 76.

Services: The program is primarily concerned with neglected children. Parent aide services will be offered directly to parents. Follow-up will be maintained through conferences with the child abuse team conducted on a weekly basis at the onset of the program.
Clientele: Individual parents are expected to be the primary clientele. Clients will be drawn from low-income urban and inner-city areas.
Staffing: The program staff will consist of lay therapists, nurses, program evaluators, and social workers.
Organization: The method of program evaluation is to be determined by the Visiting Nurses Association. The program is a collaborative effort of the Red Cross and Visiting Nurses Association.
Coordination: The Visiting Nurses Association will be the major referral source. Cases will be reported to the Visiting Nurses Association. Information will be shared with all American Red Cross Chapters.
Funding: Most of the program income will arise from voluntary agency funds.

CP-01817
Hamilton County Dept. of Welfare, Cincinnati, Ohio.
628 Sycamore St.
Cincinnati, OH 45202
Group Home Program.
S. Matlow, and D. Jazwinski.

Services: Part of the program scope is focused on abuse and neglect. Direct services to parents include social work counseling, group therapy, family counseling, individual therapy, and residential care. Most of the above services plus medical care are available though purchases: homemaking services, health counseling, employment assistance, housing assistance, and welfare assistance are available through referrals. Individual therapy and residential care are available directly to children; medical care and specialized therapy are available through purchases; and referrals may be used for some specialized therapy.
Clientele: Individual children, children in groups, and families constitute 75, 20, and 5 percent of the clients, respectively. Clients are typically drawn from low-income urban and inner-city areas.
Staffing: Child welfare personnel, lay therapists, and social workers comprise the program staff. A coordinator is shared with other residential programs.
Organization: The program is supervised by the Hamilton County Commissioners. Evaluations are performed by in-house staff and also by a court review board.
Coordination: All cases handled by the program are the result of in-house referrals; active cases are reported to the parent social welfare agency. Follow-ups of cases are conducted by the Protective Services division, as needed.
Funding: County funds support the program operations.

CP-01100
Louisiana State Div. of Family Services, Baton Rouge
P.O. Box 44065
Baton Rouge, LA 70804
Child Protection Services.
R. E. Westerfield, and J. L. Futrell
Jan 73

Services: The scope of the program covers, in part, the identification and treatment of abused and neglected children and their families. Services offered directly to families include social work counseling, couples counseling, family counseling, individual therapy, homemaking assistance, employment assistance, housing assistance, welfare assistance, and medical care. Residential care for families may be purchased, and families are referred for group therapy and family planning. Children are provided directly with day care, individual therapy, and foster care. Medical care and residential care may be purchased for children.
Clientele: In the last complete fiscal year, approximately 55 percent of those served were individual children and about 45 percent were families. Clients are from various locales and mixed income levels.
Staffing: The staff is composed of child welfare personnel, homemaker specialists, pediatricians, and a training specialist. The program plans to add attorneys and psychiatrists to the multidisciplinary teams.
Organization: The administering organization is supervised by the Louisiana Health and Human Resources Administration. For evaluation, the Monitoring and Evaluation Unit reads samples of cases following a schedule designed for that purpose. Their report is sent to a Social Service Program Administrator who meets with the Protective Service Consultant to plan corrective action.
Coordination: Sources of referrals are medical authorities, social service agencies, schools, legal authorities, parents, other concerned individuals, and self-referrals. Adjudicated cases are reported by name to the state central registry maintained by the organization and to the District Attorney. Identifying codes are sent to the National Clearinghouse for Child Abuse and Neglect in Denver. Information is also shared with regional mental health centers and parish health units. Pediatric care is purchased from the Louisiana State University Medical School.
Funding: In the last complete fiscal year, the program received approximately 25 percent of its funds from the state and approximately 75 percent from federal revenue distributed by the state.

CP-01171
Child Study Center, Inc., Fort Worth, Tex.
1300 W. Lancaster
Fort Worth, TX 76102
Psychiatric Services.
S. G. Maddox, and L. D. Eason
1956

Services: Part of the program scope encompasses child abuse and neglect. Services in the areas of prevention, treatment, and follow-up are available. Social work counseling, group therapy, family counseling, and child management classes are offered directly to parents. Children receive day care, therapeutic day care, play therapy, individual therapy, and specialized therapy services directly, with residential care services furnished through referrals. Follow-up is maintained by means of a questionnaire completed at the conclusion of treatment, a child management recall every 6 weeks, and by medical recall every 4 to 6 weeks.
Clientele: Individual children and families from mixed-income, suburban, urban, and inner-city areas are served by the program.
Staffing: The program staff consists of dentists, nurses, pediatricians, psychiatric social workers, psychiatrists, psychologists, teachers, and educational diagnosticians.
Organization: The program is conducted by a private, nonprofit mental and physical health organization. Individual case records are evaluated quarterly by an interdisciplinary team of professionals. Results of case management and degree of problem remediation are evaluated every 2 years by the Joint Commission on Accreditation of Community Agencies.
Coordination: Medical and legal authorities, social service agencies, schools, parents, and victims are the major referral sources. Cases are reported by name to the social services and health departments.
Funding: In the last fiscal year, direct federal, state, state-administered federal, county, city, and private funds accounted for 8, 26, 18, 1, 1, and 46 percent of the program income, respectively.

CP-01204
Settlement Club, Austin, Tex.
1600 Peyton Gin Rd.
Austin, TX 78758
Settlement Home.
H. Scogin
Sep 67

Services: Part of this program is concerned with abused and neglected adolescents and their families. Social work counseling, family counseling, and individual therapy are offered directly to families of residents. Children are directly provided with medical care, play therapy, individual therapy, residential care, recreational activities, and group therapy. Milieu therapy is emphasized. Many of these services are also available by purchase or referral. Adolescents over 16 may be referred to Texas Vocational Rehabilitation for job training.
Clientele: Clients are adolescents between the ages of 13 and 18 and their families. They are primarily from suburban and urban, mixed-income areas.

Staffing: The staff consists of psychiatric social workers, psychiatrists, and psychologists.
Organization: The organization is governed by the Texas Department of Public Welfare. There are individual treatment evaluations at least every 3 months which involve the entire treatment team and are under the direction of the Director of Social Services.
Coordination: Referring agencies include Child Welfare, the Texas Youth Council, various juvenile courts in Texas, child guidance clinics, school counselors, the military CHAMPUS program, parents, psychologists, doctors, psychiatrists, clients, and other concerned individuals. Cases are reported by name to the Department of Public Welfare and information is also shared with the Texas Rehabilitation Commission. The Home works closely with the public schools where the students are enrolled.
Funding: In the last fiscal year, approximately 10 percent of the program's income was from the state. About 90 percent was from private sources, including personal donations and client fees.

CP-01240
Dallas County Child Protective Team, Adel, Iowa
121 N. 9th
Adel, IA 50003
Child Protective Team.
Aug 75

Services: The program will be focused primarily on child abuse and neglect. The program is new and formalization of procedures and controls is planned in the future. Planned follow-up is by joint staff meetings at monthly and quarterly intervals.
Clientele: The program will concentrate on family treatment. Clientele will probably be from rural areas.
Staffing: Child welfare personnel, criminologists, and nurses are planned for the program staff.
Organization: The program is a public, county agency. No plan for evaluation has yet been established.
Coordination: Medical authorities, government social service agencies, schools, relatives, and acquaintances are expected to refer cases to the program. Case reports will be sent to the police or court officials, social welfare services, and the state central registry. Attorneys will be shared with the county attorney's office, nurses with the Public Health Nurses, and social workers with the State Department of Social Services.

CP-01291
Kansas Univ., Kansas City, Div. of Child Psychiatry
39th and Rainbow
Kansas City, KS 66103
Child Protection Team.
J. E. Fish.
Apr 71.

Services: The program focuses primarily on child abuse and neglect; the Team coordinates services of other agencies. Parent aides are available to parents directly; social work counseling, individual and group therapy, marriage and family counseling, child management classes, housing assistance, welfare assistance, medical care, and residential care are available through referrals. For children, medical care, play therapy, individual therapy, specialized therapy, foster care, and residential care are available through referrals. Weekly follow-up of children in the hospital is reviewed at regular team meetings; there is also follow-up of cases in treatment at various cooperating agencies and of cases scheduled for court hearing.
Clientele: Each agency involved in the team offers direct services. Those served by the programs come from mixed-income groups in suburban, urban, and inner-city areas.
Staffing: There are plans to train and assign volunteer lay therapists and to hire a full-time lay therapist supervisor.
Organization: The Team represents 2-county, state, local, and university agencies; its function is to coordinate services among agencies concerned with child abuse and neglect and to educate professional mental health, legal, and other personnel.
Coordination: Case referral sources include medical authorities, government social service agencies, schools, law enforcement agencies, courts, abuse victims, and parents. Cases are reported by name to juvenile services and social services authorities.
Funding: Program support comes from private sources.

CP-01302
Cardinal Glennon Memorial Hospital for Children, St. Louis, Mo.
1465 S. Grand Blvd.
St. Louis, MO 63104
Child Abuse Management Team.
U. T. Rolfe
Sep 73.

Services: The primary program scope is focused on child abuse and neglect, with services offered in the areas of identification, prevention, treatment, and follow-up. Social work counseling is offered directly by the program, and family counseling is available by referral to other programs. Medical care, individual therapy, and specialized therapy are available to children directly. Child health services and social services are available by referral to other programs. Medical and social service follow-up are given as indicated. Comprehensive follow-up is planned for the future, along with an increase in staffing in both medical and social areas.
Clientele: Those served are children and families from mixed-income rural, suburban, urban, and inner-city areas.
Staffing: Two full-time pediatricians, doctors, and social workers are on the program staff. Staff is shared with St. Louis University and Medical School.
Organization: The program is a private nonprofit organization under direct supervision of the Cardinal Glennon Memorial Hospital for Children; primary organization focus is on physical health and medicine. Evaluation is limited to the review of the child abuse management team.
Coordination: Medical authorities, social service agencies, schools, law enforcement agencies, courts, concerned individuals, and abuse victims refer cases to the program. Case reports are sent to the social or welfare services and the state central registry. Confidential cross reference files are shared with the St. Louis Children's Hospital, and reports are shared with the Illinois Crisis Team and the Illinois Children and Family Services.
Funding: The program income includes minimal payment of fees from individual clients and current Medicaid payment.

CP-01847
Community Council for the Prevention of Child Abuse and Neglect, Cedar Rapids, Iowa.
701 10th St. S.E.
Cedar Rapids, IA 52403
Child Abuse and Neglect Multidisciplinary Consultation Team.
M. Ward, and K. Bone.
May 76.

Services: The major function of the Team is to provide diagnostic consultation and recommendations for treatment of the Linn County Department of Social Services.
Clientele: Services to families are stressed. Clients are drawn from mixed-income, rural, and urban areas.
Staffing: The Team consists of lawyers, nurses, psychiatrists, social workers, teachers, a Parents Anonymous representative, and a law enforcement official. The addition of a physician to the team is anticipated. These volunteers serve approximately 4 hours per month.
Organization: The administering council is governed by the Linn County Board of Social Services. The program is internally evaluated on an informal basis. A Community Council Committee evaluates the team's activities, and the Linn County Social Services provides follow-up reports as to the effectiveness of the team's recommendations.
Coordination: Private physicians and government social service agencies are the major referral sources. Cases are reported by identifying code to social services authorities.

CP-01852
MEDDAC, Ft. Leavenworth, Kans.
Ft. Leavenworth, KS 66027
Army Child Advocacy Program (ACAP). Child Protection and Case Management Team (CPCMT).
B. Barter, and G. Griffin.
Sep 74.

Services: Part of the program scope focuses on child abuse and neglect. Social work counseling, couples counseling, family counseling, individual therapy, and family planning assistance are offered directly to parents. Referrals provide them with health counseling, child management classes, family planning assistance, residential care, and welfare services. Children receive medical care and individual therapy directly, and foster care service through referrals. Follow-up is maintained through home visits, outpatient visits, and social work visits conducted on a weekly to monthly basis.
Clientele: Services to military families are emphasized. Clients are drawn from mixed-income groups.
Staffing: The program staff consists of lawyers, nurses, pediatricians, psychiatrists, psychologists, and social workers who also have other duties.
Organization: The administering organization is governed by the Combined Arms Center and Fort Leavenworth. The evaluation of case management occurs at monthly team meetings. The program was formerly a Fort Leavenworth program but now has Army wide guidelines.
Coordination: Hospitals, government social service agencies, schools, law enforcement agencies, concerned individuals, and victims are the major referral sources. Cases are reported by name to the legal authorities, social services, Army Health Services Command, and to a state central registry.

CP-01854
Buffalo County Dept. of Social Services, Kearney, Nebr.
P.O. Box 218
Kearney, NE 68847
SCAN.
K. Shaffer.
Jun 75.

Services: The program is focused primarily on child abuse and neglect. The program has a crisis line for emergencies and provides parents with social work counseling, family counseling, and homemaking services. Group therapy and couples counseling are purchased for the program. Parents are referred for lay therapy or parents aides, individual therapy, health counseling, child management classes, welfare services, family planning assistance, medical care, and residential care. Day care is purchased for children. Therapeutic day care, play therapy, individual therapy, specialized therapy, and foster care are available for children through referrals. The implementation of follow-up measures is anticipated.
Clientele: The program serves individuals from rural, suburban, and urban areas, from all income levels.
Staffing: The program staff includes child welfare personnel, homemaker specialists, lawyers, pediatricians, psychologists, social workers, and teachers.
Organization: The program is an interdisciplinary organization of professionals.
Coordination: The program shares information appropriate to therapy with the Crisis Line and the South Central Nebraska Mental Health Unit. Cases are generally referred by private physicians, hospitals, schools, and neighbors, and by self-referrals. Cases are reported to the police, social welfare services, and the state central registry.

CP-01442
Montana Deaconess Hospital, Great Falls.
2601 11th Ave. S.
Great Falls, MT 59404
Montana Deaconess Hospital Child Protection Team.
M. Schuldt, and J. Severns.
Apr 75.

Services: The program is focused primarily on child abuse and neglect. Social work counseling, Parents Anonymous, couples counseling, individual therapy, and medical care are offered to parents. Meetings to call attention of concerned individuals to needs of previously hospitalized children provide follow-up.
Clientele: Those served are individual children and parents; they are primarily from mixed-income, urban areas. In the last fiscal year, 6 children and 10 parents were treated.
Staffing: Team members who spend time with children and parents include physicians, nurses, pediatricians, psychiatric social workers, and a social worker. All members except the social worker are regular hospital staff.
Organization: The program is conducted by a private, nonprofit organization.
Coordination: Medical professionals refer cases to the program. Information pertinent to the case of a hospitalized child is shared with the County Department of Social and Rehabilitation Services; a social worker is also shared with this agency.

CP-01497
Albany County Child Protection Council, Laramie, Wyo.
255 N. 30th
Laramie, WY 82070
Child Protection Treatment Team.
W. L. Edwards.
Nov 72.

Services: The program scope focuses primarily on child abuse and neglect. Services in the areas of identification, prevention, treatment, and follow-up are available. Social work counseling, lay therapy, group therapy, couples counseling, family counseling, and individual therapy services are offered directly to parents, with some of these services and homemaking services, health counseling, child management classes, residential care, medical care, family planning assistance, and welfare services obtainable through referrals. Children receive individual therapy directly, with a wide range of child care and child health services furnished through referrals. Follow-up is maintained through monthly phone calls, home visits, and contacts with referral agencies. A parent aide service has been added to the program, and the inclusion of Parents Anonymous and expanded parent aide services is anticipated.
Clientele: Individual children, children in groups, individual parents, parents in groups, and families account for 20, 5, 60, 5, and 10 percent of the clientele, respectively. Clients are drawn from mixed-income, rural and urban areas.
Staffing: The team consists of child welfare personnel, family counselors, lawyers, lay therapists, nurses, pediatricians, psychiatric social workers, psychiatrists, psychologists, social workers, and training specialists, all of whom are volunteers.
Organization: The program is conducted by an interagency council made up of public and private agencies. The program is evaluated internally, using informal methods.
Coordination: Medical and legal authorities, social service agencies, schools, concerned individuals, and victims are the major referral sources. Cases are reported by name to the legal authorities, juvenile services, social services, and to a central registry maintained by the Wyoming Department of Public Assistance and Social Services. Cases are reported by gross numbers to the Council. Information regarding needs and current status is shared with the Albany County Department of Public Assistance and Social Services, the Albany County Branch of the Southeast Wyoming Mental Health Center, and with the Albany County Public Health Nursing Service. Social workers and child welfare personnel are shared with the Public Assistance and Social Services, psychological and psychiatric personnel with the Southeast Wyoming Mental Health Center, and nurses with the public schools and with Public Health Nursing Services.

CP-01506
Platte County Dept. of Public Assistance and Social Services, Wheatland, Wyo.
Box 287
Wheatland, WY 82201
Platte County Child Protection Team.
J. Halloway.
Jun 74.

Services: The program scope focuses primarily on child abuse and neglect. Services in the areas of identification, prevention, treatment, and follow-up are available. Social work counseling, family counseling, individual therapy, homemaking services, medical care, family planning assistance, employment assistance, and welfare assistance are offered directly to parents, with some of these services also obtainable through referrals or by purchase. Children receive day care, medical care, and foster care services directly. Day care, foster care, and specialized therapy are purchased. Specialized therapy is also available by referral. Follow-up is maintained through caseworker contacts with the client and through consultation with referral agencies.
Clientele: Individual children, individual parents, and families are served. Clients are drawn from mixed-income, rural areas.
Staffing: The program staff consists of child welfare personnel, doctors, family counselors, lawyers, psychiatric social workers, psychologists, social workers, and teachers.
Organization: The administering organization is supervised by the Wyoming Child Protection Center.
Coordination: Private physicians, schools, legal authorities, concerned individuals, and victims are the major referral sources. Cases are reported by name to the legal authorities, social services, to a central registry maintained by the Wyoming Department of Public Assistance and Social Services, and to the Mental Health Service.

CP-01666
Primary Children's Medical Center, Salt Lake City, Utah.
320 12th Ave.
Salt Lake City, UT 84103
Primary Children's Medical Center Child Protection Team.
M. S. Mollanen, and M. Palmer.
Apr 76.

Services: Most of the program scope encompasses child abuse and neglect. Services in the areas of identification, prevention, treatment, and follow-up are available. Social work counseling, family counseling, individual therapy, child management classes, and medical care services are offered directly to parents. Comprehensive social, human, health, and welfare services are available to parents through referrals, including many of those available as direct services. Children receive medical care, play therapy, individual therapy, specialized therapy, and residential care services directly. A wide variety of child care and child health services are furnished to children through referrals, including many which are also available as direct services. Follow-up is maintained through written correspondence and telephone calls conducted on a quarterly basis.
Clientele: Individual children, individual parents, and families account for approximately 50, 25, and 25 percent of the clientele, respectively. Clients are drawn from mixed-income, rural, suburban, urban, and inner-city areas.
Staffing: The program staff consists of nurses, pediatricians, psychiatrists, and social workers.
Organization: The administering organization is supervised by Intermountain Health Care, Inc. Program evaluations involve the analysis of follow-up reports on clients to determine if they benefited from the services offered.
Coordination: Medical authorities and victims are the major referral sources. Cases are reported by name to the social services. Information on the type of case, services provided, and follow-up are also shared with the Utah Division of Family Services. A social worker is shared with the Utah Division of Family Services and a child psychiatrist with the Primary Children's Medical Center Psychiatric Center.
Funding: Most of the program funding is provided by the administering organization.

CP-01520
Arizona State Dept. of Economic Security, Phoenix.
P.O. Box 6123
Phoenix, AZ 85005
Child Protective Services.
J. Huerta, and D. W. Burdue.
Aug 70.

Services: The program focuses mainly on child abuse and neglect. Social work counseling, group therapy, family counseling, individual therapy, homemaking services, health counseling, family planning assistance, psychiatric evaluations, and psychological evaluations are offered to parents directly; parent aides, family planning assistance, and medical care are available through puchases; and Parents Anonymous, health counseling, child management classes, and assistance in employment, housing, welfare, and family planning are available through referrals. For children, day care, individual therapy, foster care, residential care, psychiatric examination, and psychological evaluation are offered directly; therapeutic day care, medical care, and individual therapy are available through purchases, and specialized therapy is available through referrals.
Clientele: In the last fiscal year, 10,837 individual children and 5,795 families from rural, suburban, urban, and inner-city, mixed-income areas were provided identification, treatment, and follow-up services.
Staffing: Social workers and child welfare personnel comprise the staff. Since the inception of the program there has been a significant increase in staff, and use of child abuse teams has been initiated; use of emergency caretakers and homemakers is anticipated in the near future.
Organization: This is a state-wide program. Program Evaluation and Development, Social Services Bureau, reads a random sample of cases statewide to determine whether State Law and the Department of Economic Security manual guidelines are followed. A Social Services Consultant makes field visits to each local office on a continual basis and prepares written evaluation after each visit.
Coordination: Medical authorities, social service agencies, schools, law enforcement agencies, courts, abuse victims, and other concerned individuals refer cases to the program. Cases are reported to the police and judiciary and to a state central registry maintained by the Department of Economic Security. Pertinent information is shared with law enforcement personnel and with the medical profession.
Funding: In the last fiscal year, program support came entirely from state funds.

CP-01582
Monterey County Dept. of Social Services, Salinas, Calif.
P.O. Box 299
Salinas, CA 93940
Crisis Intervention Continuum.
E. Deasy, and J. Phan.
Sep 72.

Services: Part of the program scope encompasses child abuse and neglect. Services in the areas of identification, prevention, treatment, and follow-up are available. Social work counseling, parent aide, couples counseling, family counseling, individual therapy, homemaking services, health counseling, family planning assistance, and welfare services are offered directly to parents, with some of these services, child management classes, and medical care services obtainable through referrals. Children receive foster care services directly, with day care, medical care, individual therapy, specialized therapy, and residential care services purchased from another program or furnished through referrals. Follow-up is accomplished through staffings conducted 3 times a year and through personal visits conducted on a weekly or semiweekly basis. The establishment of a Parents Anonymous service is anticipated. The program is a task force system which works cooperatively in the area of child abuse and neglect.
Clientele: Individual children, individual parents, and families are served. During the last fiscal year, identification, prevention, treatment, and follow-up services were provided to 2,502, 400, 2,502, and 2,502 individual children, respectively; to 745, 316, 745, and 745 individual parents, respectively; and to 510, 80, 510, and 510 families, respectively. Clients are drawn from mixed-income, rural, suburban, and urban areas.
Staffing: The program staff consists of homemaker specialists, program evaluators, social workers, and training specialists.
Organization: The administering organization is governed by the Monterey County Board of Supervisors. Program plans and goals are reviewed through staffings. Cases are reviewed by the Accountability Supervisor.
Coordination: Medical and legal authorities, private social service agencies, schools, concerned individuals, and victims are the major referral sources. Cases are reported by name to the legal authorities and to the social services. The follow-up plan is shared with the Monterey SCAN team. Social workers are shared with the El Sausal Junior High School and with the Volunteer Bureau. A Woman-to-Woman program is purchased from the Volunteer Bureau, and training for employment services is purchased from Sav-a-Work, a rehabilitation program.
Funding: In the last fiscal year, state, state-administered federal, and county funds accounted for 7, 75, and 18 percent of the program's income, respectively.

CP-01593
Monterey Peninsula Youth Project, Calif.
467 Alvarado
Monterey, CA 93940
Community Counseling Center.
M. McPherson, R. Leep, and J. M. Gallagher.

Services: A part of the program scope focuses on child abuse and neglect. Group therapy, Parents Anonymous, couples counseling, family counseling, individual therapy, health counseling, and family planning assistance services are offered directly to parents. Child management classes, medical care, residential care, and welfare services are obtainable through referrals. Children receive play therapy and individual therapy directly; day care, therapeutic day care, specialized therapy, foster care, and residential care services are furnished through referrals. Follow-up is accomplished on a monthly basis through direct contact, phone calls, and letters. The focus of the program has changed from drug abuse to families and children in crisis. Direct counseling supervision has greatly increased since the program's inception. Solidification of school counseling programs and the expansion of group counseling services to youths are anticipated.
Clientele: Individual children, children in groups, individual parents, parents in groups, and families account for 40, 10, 20, 10, and 20 percent of the clientele, respectively. Clients are drawn from mixed-income, suburban and urban areas.
Staffing: The program staff consists of family counselors and lay therapists. Staff expertise has increased markedly since the program's inception.
Organization: The program is conducted by a private, nonprofit mental health organization. Internal program evaluation is maintained by the Management Team, the Counseling Coordinator, the Clinical Director, and the Executive Director through counseling supervision, review of interview tapes, chart review, and follow-up questionnaires to agencies. A total program evaluation is conducted by the Mid Coast Comprehensive Mental Health Association.
Coordination: The program is affiliated with Parents Anonymous. Medical and legal authorities, government social service agencies, schools, parents, and victims are the major referral sources. Cases are reported by name to legal authorities and juvenile services. General progress information is shared with the Community Hospital, school personnel, and the Suicide Prevention Service, with the clients' permission.
Funding: In the last fiscal year, county, municipal, and private funds accounted for most of the program's income. Some of the program income was provided by the school districts of Monterey, Pacific Grove, and Carmel counties.

CP-01639
YWCA, Monterey, Calif.
P.O. Box 1362
Monterey, CA 93940
Monterey Peninsula Child Abuse Prevention Council.
P. Fall, and E. Feeney.
Apr 75.

Services: Most of the program scope encompasses child abuse and neglect. Social work counseling, couples counseling, family counseling, individual therapy, child management classes, employment assistance, welfare assistance, family planning assistance, and medical care services are offered to parents through referrals. Children receive day care, medical care, individual therapy, specialized therapy, foster care, and residential care services through referrals. The program serves as a clearinghouse for information on child abuse. A list of community resources in this area will be prepared and efforts will be made to bring parent education into the curricula of all high schools. The establishment of a professional committee of physicians, lawyers, police officers, and social workers to meet periodically for the diagnosis and treatment of selected child abuse cases, and the establishment of a team to deal with long range treatment, education, research, services, and follow-up for the program's are anticipated.
Clientele: Clients are drawn from mixed-income, rural, suburban, and urban area.
Staffing: The program staff consists of a program coordinator.
Organization: The administering organization is governed by the Monterey County Board of Supervisors.
Coordination: Information is shared with the Monterey County Department of Social Services - Children's Protective Services and with the Joint Child Protection Team of Community Hospital of Monterey Peninsula. Staff is shared with other programs conducted by the organization.
Funding: In this fiscal year, the county will provide most of the program's income.

CP-01653
Sisters of the Good Shepherd of Las Vegas, Inc., Nev.
7000 N. Jones Blvd.
Las Vegas, NV 89106
Home of the Good Shepherd (Marie Saint Yves School).
Sister M Celine, and Sister M Annunciata.
Aug 82.

Services: Part of the program focus is on child neglect. Social work counseling, group therapy, couples and family counseling, individual therapy, health counseling, child management classes, employment assistance, medical care, residential care, aftercare, and crisis day-care prevention are offered to parents. Day care, therapeutic day care, medical care, individual therapy, residential care, and group homes are offered to children. Follow-up is offered for 3 months after the return home on a trial basis, and aftercare is offered for 1 year.
Clientele: Children individually and in groups, parents, and families from mixed-income suburban and urban areas are served by the program.
Staffing: Child welfare personnel, dentists, physicians, family counselors, lay therapists, nutritionists, pediatricians, psychiatric social workers, social workers, and teachers comprise the staff.
Organization: This is a private, nonprofit organization under the supervision of the Provincial Convent of The Good Shepherd, St. Louis, Missouri. Program performance is evaluated in-house by a team approach method.
Coordination: Private social service agencies, schools, law enforcement agencies, courts, prospective clients, and parents refer cases to the program. Cases are reported by name to juvenile services and social services authorities. Information on the status of children and on program development is shared with the National Council of Juvenile Judges in Reno. Staff are shared with Nevada Mental Health and Vocational Rehabilitation programs.
Funding: Program support comes from state funds, personal donations, and client fees.

CP-01654
Washoe County Dept. of Health, Reno, Nev.
10 Kirman
Reno, NV 89510
Child Neglect and Trauma Center.
V. D'Atri.
Dec 14.

Services: The program focus is on child abuse and neglect. Social work counseling is offered to parents directly; social work counseling, group therapy, Parents Anonymous, family and couples counseling, and individual therapy are available through referrals. For children, day care, therapeutic day care, medical care, individual therapy, and foster care are available through referral. Changes in the program since its inception include provision for early intervention and treatment through case conferences including involved professionals, development of a speakers bureau, involvement of the judicial component, and development of a respite care center. Future plans include increasing emphasis on public education, establishment of a family stress center, training of professionals and paraprofessionals, expansion to a 24-hour reporting service, establishment of a multidisciplinary team, and efforts toward sensitization of the legal system to a child advocacy role.
Clientele: Individual children (90 percent of the total clientele), individual parents (5 percent), and families (5 percent) from a wide variety of locales and mixed-income levels are provided identification and follow-up services.
Staffing: The Coordinator also serves as administrator, training specialist, and data gatherer.
Organization: The program is governed by the Northern Nevada Task Force on Child Abuse and Trauma. It provides a non-punitive outlet for reporting. Other objectives are to improve communication between existing agencies and resources, to design programs, and to inform and educate the community. Program performance is evaluated from periodic reports to the District Health Officer and quarterly reports to the Mountain States Regional Medical Program (grantor).
Coordination: Medical authorities, government social service agencies, schools, law enforcement agencies, abuse victims, and other concerned individuals refer cases to the program. Cases are reported by name to the police and judiciary, and to social and welfare services, health departments, day care centers, and hospitals; they are reported by gross numbers only to a state central registry maintained by the Nevada State Welfare Division. The Coordinator works with the Reno Police Department and Washoe County Sheriff's Department, Nevada State Welfare Division and Washoe County Welfare Department, the University of Nevada and the Washoe County School District, and the Washoe Medical Center and St. Mary's Hospital.
Funding: In the last fiscal year, program support came entirely from direct federal funds.

CP-01655
San Francisco Dept. of Social Services, Calif.
P.O. Box 7988
San Francisco, CA 94120
Child Protective Services.
R. Farrington, and A. Ghosh.
1955.

Services: Most of the program scope encompasses child abuse and neglect. Services in the areas of identification, prevention, treatment, and follow-up are available. Social work counseling, parent aides, group therapy, family counseling, individual therapy, health counseling, family planning, housing, employment, and welfare services are offered directly to parents, with social work counseling, group therapy, family counseling, individual therapy, health counseling, child management classes, family planning assistance, legal counseling, and homemaking services available through referrals. Children receive play therapy, individual therapy, foster care, and residential care services directly, with day care, medical care, and specialized therapy furnished through referrals. Therapeutic day care is purchased from another program. Follow-up is maintained by another agency.
Clientele: Clients are served primarily as family units. During the last fiscal year, identification, prevention, treatment, and follow-up services were provided to 1734 children and 863 families. Clients are drawn from mixed-income urban areas.
Staffing: The program staff consists of child welfare personnel and social service technicians.
Organization: The administering organization is governed by the California State Department of Health. Administrative review is conducted by the Assistant Direct of the program, with state and federal audits also conducted periodically.
Coordination: Medical and legal authorities, social service agencies, schools, concerned individuals, victims, and day care personnel are the major referral sources. Cases are reported by name to the legal authorities, juvenile services, and to a state central registry. All case information is shared with the Juvenile Probation Department, and information is shared with other social agencies with the client's permission. A more formalized team approach with the Juvenile Probation Department is being undertaken, which includes sharing of facilities.
Funding: Direct federal funds accounted for 75 percent of the program finances during the last fiscal year; county and city funds accounted for the remaining 25 percent.

CP-01680
Children's Orthopedic Hospital, Seattle, Wash.
Dept. of Behavioral Sciences
4800 Sand Point Way N.E.
Seattle, WA 98105
Child Abuse Team.
A. Kamm, and J. Raskin.
Jul 70.

Services: The scope of this program is focused on child abuse and neglect. Day care, therapeutic day care, medical care, play therapy, and individual therapy are provided directly for children. Services provided directly to families include social work counseling, lay therapy, group therapy, family counseling, individual therapy, and housing assistance. Follow-up includes weekly family counseling and weekly group therapy sessions.
Clientele: Parents and children from urban, low-income groups are served by this program.
Staffing: The staff consists of social workers, psychologists, pediatricians, physicians, psychiatrists, and other medical specialists.
Organization: The organization is supervised by its Board of Trustees.
Coordination: Cases are referred to the program by physicians, public and private social service agencies, schools, legal authorities, relatives, and the clients themselves. They are reported to social agencies.
Funding: During the last fiscal year, approximately 66 percent of the program income was derived from county sources; 34 percent from private sources.

CP-01681
Coalition for Child Advocacy, Bellingham, Wash.
P.O. Box 159
Bellingham, WA 98225
Coalition for Child Advocacy.
M. Day, and J. Duff.
Oct 74.

Services: Most of the program scope encompasses child abuse and neglect. The first goal of the program is to provide a cooperative community-based method for planning and delivery of services to prevent and remediate child abuse and neglect in Whatcom County. As of September 1975, efforts directed toward such a goal have been in five areas: service planning, legislative advocacy, interagency cooperation, 24-hour telephone consultation, and information and referral. A parent aide service is offered directly to parents; a wide range of social, health, and welfare services is obtainable through referrals. A wide variety of child care and child health services are available to children through referrals. A second goal of the program is to increase knowledge of in the county concerning child abuse and neglect. Activities directed toward this goal have been in the areas of analysis of local child protective service reports, professional and paraprofessional training, public education, and public relations. Another goal of the program is to increase reporting of cases of suspected abuse and neglect.
Clientele: Individual children, individual parents, and families are served. Clients are drawn from mixed-income, rural and suburban areas.
Staffing: The program staff consists of a coordinator and volunteers.
Organization: The administering organization is governed by the Whatcom County Opportunity Council. The program is evaluated through examination of stated goals, planned activities, and quantifiable or specific accomplishments by the Coalition and by the Whatcom County Opportunity Council.
Coordination: Social service agencies, schools, concerned individuals, and victims are the major referral sources. Cases are reported by name to the social services and by identifying code to the program's assessment team. Educational information is shared with any program, organization, or individual.
Funding: In this fiscal year, state-administered federal and private funds accounted for 99.5 and .5 percent of the program income, respectively.

CP-01692
Panel for Family Living, Inc., Tacoma, Wash.
1115 S. 4th St.
Tacoma, WA 98405
Coordinating Community Concern for Child Abuse and Neglect.
C. Narr.
May 74.

Services: Most of the program scope encompasses child abuse and neglect. Services in the areas of treatment and follow-up are available. Social work counseling, parent aide, group therapy, couples counseling, child management classes, and medical care services are offered directly to parents, with Parents Anonymous, health counseling, medical care, family planning assistance, and welfare services obtainable through referrals. Follow-up is accomplished through a single home visit conducted at 30 to 90 days after case closure and through phone calls conducted as needed. A multidisciplinary diagnostic team now offers consultation to professionals in the community who are serving abusive or neglected families.
Clientele: Individual parents and parents in groups are served. During the last fiscal year, treatment and follow-up services were provided to 14 and 9 individual parents, respectively; and to 56 and 38 parents in groups, respectively. Clients are drawn from low-income, suburban and urban areas.
Staffing: The program staff consists of program evaluators, training specialists, social workers, an outreach worker, and an office manager. The social worker supervises direct services.
Organization: The program is conducted by a private, nonprofit social service agency. The design of service evaluation is being revised. It is expected that methods consistent with single individual research will be employed. Multiple measures will be used adapted to this style. General program evaluation under contract with the Department of Health, Education, and Welfare is maintained by Berkeley Planning Associates, Berkeley, California.
Coordination: Social service agencies, schools, courts, legal aid, public health nurses, and victims are the major referral sources. Cases are reported by name to the State Department of Children's Protective Serviceservices. Information is shared with the American Humane Association utilizing a standard reporting form.
Funding: In the last fiscal year, direct federal, county, and private funds accounted for 99.0 5, and 0.5 percent of the program income, respectively.

CP-01697
Suspected Child Abuse and Neglect (SCAN) Center, Spokane, Wash.
105 W. 8th Ave.
Spokane, WA 99204
Suspected Child Abuse and Neglect Program.
D. E. Feehan.
Oct 73.

Services: The program focuses on child abuse and neglect. Lay therapy and Families Anonymous services are offered directly to families. They are referred for a variety of special, health, welfare, and social services. Children are referred for day care, therapeutic day care, medical care, play therapy, individual therapy, specialized therapy, foster care, and residential care. Community services include a 24-hour hot line, a speakers bureau, an information center, and promotion of good parenting. Follow-up is accomplished by twice monthly telephone contacts, monthly volunteer meetings with an assigned volunteer and Assessment Team meetings upon request. A Base Line Data System has been developed to determine abuse or neglect risk factors in parents.
Clientele: The client profile generally consists of 75 percent individual parents, 5 percent parents in groups, and 20 percent families. In the last fiscal year preventive services were delivered to 80 individual parents, 15 parents in groups, and 80 families. Clients are primarily from urban, mixed-income areas.
Staffing: The program employs lay therapists, social workers, child welfare personnel, nurses, and a research specialist. A lawyer, a pediatrician, and a psychiatrist serve as consultants.
Organization: The organization is supervised by its Board of Directors. The program is evaluated internally by an evaluation committee and externally by the State Divison of Health.
Coordination: Sources of referrals are medical authorities, social service agencies, schools, relatives and clients. Cases are reported by name to social service authorities. Information is shared with various professionals in the community, civic organizations, and the school district. The Executive Director is shared with the Washington Association for Retarded Citizens; a social worker is shared with Voluntary Action; and nurses are shared with the Washington Nurses Association and the Public Health District. An increased public awareness campaign is planned.
Funding: In the last fiscal year, approximately 45 percent of the program's financial support was provided by the county; about 55 percent was contributed by voluntary agencies and personal donations. Sponsors include the Department of Social and Health Services, the Junior League of Spokane, Catholic Charities, Inc., and the United Way of Spokane.

CP-01701
Washington State Dept. of Social and Health Services, Wenatchee
Box 398, Chelan St.
Wenatchee, WA 98801
SCAN Diagnostic Team.
R. Bonifaci, B. Johnson, and D. Newell.
Jul 73.

Services: The scope of this program focuses on child abuse and neglect. Services offered directly to families include social work counseling, lay therapy, couples counseling, family counseling, individual therapy, and homemaking services. Medical care, residential care, and family planning assistance are purchased from families, and they are referred for welfare services. Children are directly provided with individual therapy. Day care, medical care, specialized therapy, and residential care are purchased for children and they are also referred for foster care.
Clientele: In the last fiscal year, 415 individual children and 164 families were identified, and 350 children and 82 families were treated. Clients are from various locales and income levels.
Staffing: The staff is comprised of homemaker specialists, lay therapists, and social workers.
Organization: The organization is supervised by the Washington State Department of Public Assistance.
Coordination: Sources of referrals are medical and legal authorities, social service agencies, schools, parents, other concerned indivi als, and clients. Cases are reported by name to a state central registry maintained by the Department of Social and Health Services. Information is also shared with the Wenatchee School District, the juvenile court, and the Chelan-Douglas Health District.

CP-01886
Fairbanks Health Center, Alaska.
800 Airport Way
Fairbanks, AK 99701
Child Protection Task Force.
C. Brice, and D. Schorr.
May 73.

Services: Most of the program scope encompasses child abuse and neglect. Services in the areas of identification, prevention, and follow-up are available. Parent aide services are offered directly to parents. Social work counseling, couples counseling, family counseling, and child management classes are available to parents through referrals. Children receive day care, individual therapy, and foster care services through referrals.
Clientele: Individual children, children in groups, individual parents, and families account for approximately 5, 5, 10, and 80 percent of the clientele, respectively. Clients are drawn from mixed-income, suburban and urban areas.
Staffing: The program staff consists of child welfare personnel, doctors, homemaker specialists, lay therapists, nurses, pediatricians, psychiatric social workers, psychologists, social workers, teachers, clergy, and a day care coordinator. All are volunteers.
Organization: The Task Force is governed by the Division of Mental Health, the Division of Social Services, and Fairbanks Health Center.
Coordination: Medical authorities, government social service agencies, schools, parents, neighbors, and victims are the major referral sources. Cases are reported by name to the social services and health departments, and by gross numbers to a state central registry.
Funding: During the last fiscal year, a service organization provided most of the program income.

Appendix B

Guidelines for Child Abuse and Neglect

Multidisciplinary Teams

The guidelines in this Appendix are reproduced with the permission and cooperation of the Virginia State Department of Welfare and the Pennsylvania State Department of Public Welfare. For additional copies of these publications, please contact:

Commonwealth of Virginia
Department of Welfare
8007 Discovery Drive
Richmond, Virginia 23288

Bureau of Public Education
Pennsylvania Department of Public Welfare
P.O. Box 2670
Harrisburg, Pennsylvania 17120

(Publication Number PWPE 28 12-77)

Recommended Guidelines for Community-Based Multidiscipline Teams for Child Protection

Commonwealth of Virginia
Governor's Advisory Committee on
Child Abuse and Neglect
1977

PREFACE

The General Assembly of Virginia in session during the winter of 1975 amended the Code of Virginia by adding in Title 63.1 a chapter numbered 12.1 containing sections numbered 63.1-248.1 through 63.1-248.17. The addition established the statute of the State regarding child abuse and neglect, defined certain pertinent terms, set the framework for reporting, and encouraged the fostering of multi-discipline community and hospital-based teams within each locality.

> "The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based multidiscipline teams which shall include where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children, coordinating medical, social, and legal services for the children and their families, helping to develop innovative programs for detection and prevention of child abuse, promoting community concern and action in the area of child abuse and neglect, and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect. The local department shall also coordinate its efforts in the provision of these services for abused and neglected children with the judge and staff of the court."
>
> (Chapter 12.1, Section of 63.1-248.6, E, Code of Virginia)

Although the local welfare departments were charged with "fostering" local teams, the same section suggests that public and private agencies as well as community groups and interested citizens be involved in the team.

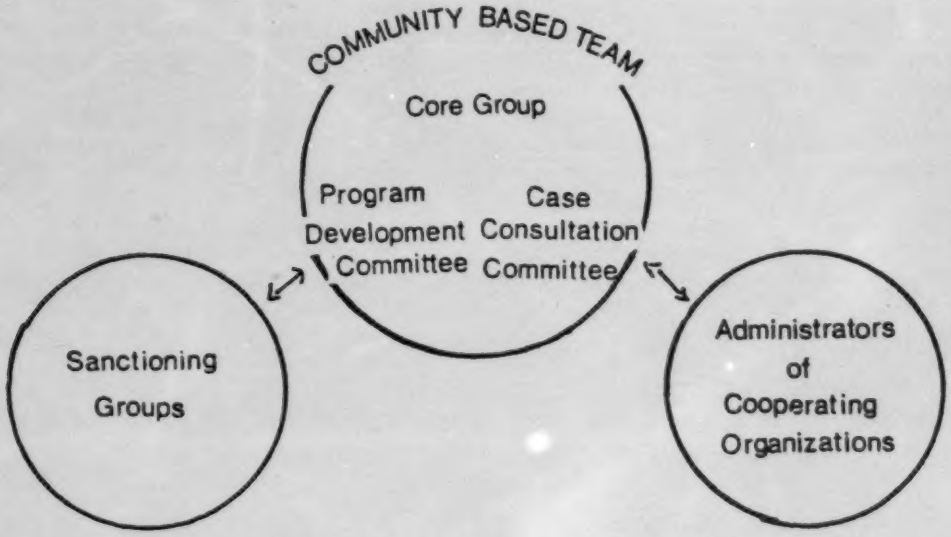
Almost immediately, a need arose for some standards and guidelines to structure and give direction to the teams. Therefore, the Governor's Advisory Committee on Child Abuse and Neglect (also established by the aforementioned Code amendments) designated a subcommittee to perform such a function on behalf of the local teams.

Meanwhile, Region III of the Department of Health, Education, and Welfare signed a contract with the consulting firm Development Associates, Inc., to provide assistance to State groups as they began to structure programs for child abuse and neglect.

The material presented here is the result of the work of a subcommittee of the Governor's Advisory Committee on Child Abuse and Neglect consulting with representatives of Development Associates, Inc. Represented on the subcommittee were an established hospital-based team from the University of Virginia, the York County School Board, the Chesterfield-Colonial Heights Protective Services, The State Department of Corrections, the Orange County Welfare Department, a multi-discipline team in Virginia Beach, a mental health clinic in Martinsville, a health department in Abingdon, the Bureau of Child Protective Services and the general public.

Teams around the State provided advice and critical reaction as the subcommittee's work progressed.

The standards and guidelines presented here are based on the following model, which evolved from several currently in use about the State. This model seems effective for the broad range of situations existing throughout the State, but it should be considered eclectic, adaptable, and evolving.



In order for a multi-disciplinary child abuse and neglect team to meet the full spectrum of a community's needs, the team should consist of two general components or committees: a Case Consultation Committee and a Program Development Committee. Other committees may be developed, but it is conceived that they will either be components of these two general committees or they will be ancillary to them.

Development of the two committees is anticipated to be gradual. Either committee may be developed first — depending on the community's most pressing and immediate needs — with the second committee eventually evolving out of the first one.

The process will generally start with a small core group of highly interested and concerned citizens who see a need for case consultation on child abuse and neglect cases and/or the development of programs and services to provide community education, treatment and prevention, etc. The core group will coordinate efforts to form and develop one or both of these two committees in order to meet these needs.

Although the guidelines listed in this packet are only *suggestions* for developing a child abuse and neglect team, they may be considered basic requirements for developing a team that can adequately meet the community's need for prevention, identification and treatment of child abuse and neglect. When a system is developed for evaluating the quality of multi-disciplinary child abuse and neglect teams, these are the standards on which teams will be evaluated.

Guidelines for implementation may be considered more flexible and subject to change from one community to another since each community can be expected to take into consideration its own unique resources.

Although it will undoubtedly take different communities different lengths of time to fully implement each standard, it is expected that all communities will eventually develop a fully functioning team incorporating each of them.

The responsibility for meeting these standards is the responsibility of the total community rather than any particular agency. However, it is expected that the impetus for forming the core group will come from the local welfare department.

The present subcommittee hopes to continue to function and to provide regional support services throughout the Commonwealth. It is foreseen that evaluative, educational, and training techniques can be provided by a permanent subcommittee on multi-discipline teams.

The committee welcomes your comments and criticisms. Send comments and suggestions to:

Chairperson, Sub-Committee on Multi-discipline Teams
c/o State Department of Welfare
Bureau of Child Protective Services
8007 Discovery Drive
Richmond, VA 23288

Persons responsible for writing these guidelines are:

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I. TEAM PURPOSE, FUNCTIONS, AND ORGANIZATIONAL ISSUES

A. THE COMMUNITY BASED TEAM SHALL HAVE A WRITTEN STATEMENT CLEARLY IDENTIFYING ITS MISSION OR PURPOSE.

- This statement should include:

  1. measurable goals.
  2. priorities.
  3. specific objectives leading to the achievement of goals.
  4. action steps, members responsible and deadlines.

B. THE COMMUNITY BASED TEAM SHALL OBTAIN SANCTION AND SUPPORT FROM INFLUENTIAL GROUPS IN THE COMMUNITY.

- Sanctioning should be sought as early as possible in the team's development.
- The team should advise political leadership of its effort and submit periodic reports.
- Team members should seek sanction and support from their respective boards.
- The team should seek sanction and support from the local juvenile court and from the commonwealth's attorney, county attorney or city attorney.
- The team should develop alignments with other citizen groups and representatives of the private sector.

While the ultimate sanction for reducing the incidence of child abuse and neglect is based in law, the need for having everyone in the community understand and support the effort is obvious. Without this support, protective services and the community based team will be working in a vacuum. With the broadest community support that can be secured, everyone will become a part of the challenge, and the children will be the beneficiaries.

C. THE COMMUNITY BASED TEAM SHALL HAVE A WRITTEN STATEMENT OF OPERATING PROCEDURES.

- This statement should include:

  1. a method of electing a chairperson.
  2. responsibilities of the chairperson and members.
  3. terms of service of the chairperson and members.

4. frequency of meetings.

5. convenient time and locations of meetings.

6. procedure for the conduct of meetings.

- Plans and mechanisms should be developed for continuous communication and coordination of efforts with sanctioning bodies and with other pertinent groups, public and private.

- The team may need to establish small, temporary subcommittees to undertake specific tasks.

D. THE COMMUNITY BASED TEAM SHALL BE PERMANENT SINCE EFFECTIVE SERVICE, PLANNING, AND COORDINATION ARE ENDURING PROCESSES. THE COMMUNITY BASED TEAM SHALL DEVELOP PROCEDURES TO INSURE COMMUNICATION AND COORDINATION AMONG ITS COMPONENTS.

- A firm link must exist between the Program Development Committee and the Case Consultation Committee through the core group.

- A member of the core group should serve as liaison between any temporary subcommittee and the team.

- The team members should understand how each organization represented on the team functions.

- Each member should be responsible for insuring that other members understand their professional "language."

II. COMMUNITY DEFINITIONS OF CHILD ABUSE AND NEGLECT AND STANDARDS OF CARE

A. THE COMMUNITY BASED TEAM SHALL RECOGNIZE THE COMMUNITY CONTEXT IN WHICH CHILD ABUSE AND NEGLECT OCCUR (COMMUNITY VALUES, INDIGENOUS PROBLEM SOLVING TECHNIQUES, CHILD-REARING TRADITIONS, RESOURCES AND LEADERSHIP) IN THE DEVELOPMENT OF PROGRAMS FOR TREATMENT AND PREVENTION OF CHILD ABUSE AND NEGLECT.

- The team should identify sources of leadership in both the public and private sector.

- The team should identify strengths in the community that help or could help in preventing child abuse and neglect.

- The team should identify social and economic problems and lifestyle patterns in the community that contribute to the problems of child abuse and neglect.

B. WITHIN THE FRAMEWORK OF THE STATE CHILD ABUSE AND NEGLECT LEGISLATION AND GUIDELINES OF THE DEPARTMENT OF PUBLIC WELFARE, THE TEAM SHALL DEVELOP AN OPERATIONAL DEFINITION OF ABUSE AND NEGLECT TO GUIDE ORGANIZATIONS AND INDIVIDUALS IN IDENTIFYING AND REPORTING.

- The definition should reflect community as well as professional standards and should be sufficiently broad for casework and preventive intervention. The definition should be reflective of the guidelines issued by the State Department of Welfare. The definition should consider the varying child-rearing practices in the community.

C. WITHIN THE FRAMEWORK OF EXISTING REGULATIONS, THE COMMUNITY BASED TEAM SHALL DEVELOP REALISTIC AND ATTAINABLE STANDARDS AND GUIDELINES FOR USE BY COOPERATING AGENCIES AND INDIVIDUAL PROFESSIONALS IN WORKING WITH CHILD ABUSE AND NEGLECT CASES.

- The standards and guidelines should include:

1. joint diagnostic evaluation.
2. criteria for treatment plans.
3. criteria for format and timing of case review.
4. criteria for maximum caseload for team.
5. policies on follow-up of terminated or stabilized cases.
6. procedures for monitoring follow-up contacts.

Just as operational definitions can differ among communities, so also do the level of resources, leadership, decision-making processes, and cultural backgrounds. It is not possible, therefore, to develop standards and guidelines for service delivery that apply to every community situation. The team should bear in mind that if standards are set too low, they may be easily achieved but restrict progress. On the other hand, standards that are set too high may never be attainable in some communities, and frustration can be the result. By determining desirable patterns of services that are within the realm of reality and practicality, teams can measure needs by comparing existing patterns with the desirable ones. This process will provide the necessary groundwork for thorough program planning and development.

III. SIZE AND COMPOSITION OF COMMUNITY BASED TEAMS

A. THE SIZE AND COMPOSITION OF A COMMUNITY BASED TEAM WILL DEPEND ON THE TEAM'S FUNCTION AND PURPOSE WITHIN THE GEOGRAPHIC AREA.

- The membership of the community based team should consist of a core group whose membership remains relatively permanent and a resource group whose membership varies according to the need of the team for consultation.

The core group should draw its membership from those who have given impetus to the formation and development of the community based team and who have shown regular attendance at the team's meetings. This should be a relatively stable group whose broad function is to act as a steering committee for the community based team. Specific functions of this group may include program planning and coordination as well as communication and liaison between the team's committees. It is recommended that membership of this group not exceed six.

The resource group should have an open-ended membership consisting of people who are invited to participate on the community based team for varying lengths of time determined by the core group and who function as case or program consultants to the community based team. The membership of this group need not be limited and should be comprised of people who agree to participate on the team for specific projects or tasks relevant to their areas of skill, knowledge, or community influence.

B. THE TEAM SHALL REFLECT THE RANGE OF PREVENTIVE AND TREATMENT RESOURCES AVAILABLE TO ABUSED AND NEGLECTED CHILDREN. IT SHALL INCLUDE PEOPLE INTERESTED AND WILLING TO PARTICIPATE ACTIVELY IN THE IDENTIFICATION, DEVELOPMENT AND EVALUATION OF PROGRAMS RELEVANT TO CHILD ABUSE AND NEGLECT.

- The membership of the community based team (i.e. core and resource people) shall be divided into a Case Consultation Committee and/or a Program Development Committee. The community based team may function in either one or both of these areas, depending on the continuing needs of the community in which the team is developed.

- The Case Consultation Committee should be restricted to community based team members who have the professional expertise necessary to identify and plan for treatment of child abuse and neglect cases. Individuals with knowledge of a specific case to be staffed by the Case Consultation Committee may be invited to participate on the committee for whatever length of time required for their consultation. This committee may include both agency and privately employed professionals and should involve people with a broad range of treatment and management knowledge, such as physicians, ministers, school personnel, psychologists, psychiatrists, social workers, law enforcement officials and health professionals. The specific professions represented will vary with both availability as well as the demonstrated or expected contribution they may be expected to make to the committee. Where possible, these professionals should be drawn from local treatment agencies in order to provide a referral liaison between the committee and the agency. Agency professionals should have sufficient authority to accept referrals to their own agency as well as to represent their agencies' policies and procedures.

- The Program Development Committee should include community based team members who are agency as well as nonagency personnel. This committee should represent a cross-section community in demographic characteristics determined necessary by the Program Development Committee and may include representatives from civic groups, volunteer organizations, business and government. Members chosen for this committee should have skills, knowledge or influence necessary for contributing to program organization, coordination and evaluation as well as acquisition of funding. These members should also have demonstrated an interest and concern about child abuse and neglect in their community.

C. IF A MILITARY INSTALLATION EXISTS WITHIN THE AREA OF A COMMUNITY BASED TEAM, A REPRESENTATIVE FROM THE MILITARY SHALL BE INVITED TO BE ON THE TEAM.

IV. AREA AND COVERAGE OF COMMUNITY BASED TEAM

A. SUFFICIENT POPULATION SHALL BE ONE FACTOR IN DETERMINING THE AREA TO BE SERVED BY A COMMUNITY BASED TEAM AS WELL AS THE COVERAGE THAT CAN BE REASONABLY PROVIDED.

- The population base might differ for the Case Consultation Committee and the Program Development Committee of the team. A Program Development Committee might take as its scope an area as comprehensive as an individual welfare region; however, a Case Consultation Committee should be limited to a single municipality or a section thereof and perhaps to one or more of its neighboring jurisdictions.

B. THE AREA CHOSEN FOR COVERAGE SHALL NOT EXCEED PROSPECTS FOR ADEQUATE FUNDING TO ACHIEVE TEAM GOALS.

- Combined jurisdiction might guarantee a better financial base.
- Financial support for the team will come primarily from the budgets of participating agencies.
- Time and services may be donated by core and resource members of the team.
- There should be cooperative efforts between the public and private sectors in exploring the use of Title XX funds and other possible sources of funding.
- Supportive services may be provided by sponsoring organizations or groups. These can include such items as duplicating, clerical assistance, postage, etc.

C. COMMUNITY INTERESTS, LOCAL MORES, BUSINESS AND SOCIAL FACTORS AND TRANSPORTATION SYSTEMS ARE IMPORTANT CONSIDERATIONS OF AREA AND SCOPE OF COVERAGE.

- The team should determine whether the area has common problems amenable to solution through joint efforts.
- There should be a basic interpretation of community standards and values.
- Services should be accessible within a reasonable travel time.
- Existing transportation systems should be considered in developing services.

D. THE DISTANCE TO BE TRAVELLED BY ANY TEAM MEMBER TO ATTEND MEETINGS SHALL BE A LIMITING FACTOR ON AREA COVERAGE.

- A team member's travel time should not exceed two hours a day.

V. CITIZEN PARTICIPATION ON A COMMUNITY BASED TEAM

A. THE COMMUNITY BASED TEAM SHALL DEVELOP MECHANISMS FOR CITIZEN PARTICIPATION SO AS TO ASSURE AN ACCURATE VIEW OF AREA NEEDS, PATTERNS, AND TOTAL CITIZEN SUPPORT.

- The Community Based Team should encourage the participation of nonagency people. This will allow concerned citizens to share leadership and guidance in the planning and development of programs.
- Procedures for choosing nonagency members should reflect the community make-up, such as patterns of ethnic, racial, and economic levels. Other factors would include a willingness to serve and an interest and concern in the area of abuse and neglect.

- The Community Based Team should develop relationships with volunteer and citizen groups.

- The Community Based Team meetings dealing with community needs assessment, program planning and program evaluation should be open to the public.

- The team should develop regular communications with all segments of the community.

VI. PROGRAM DEVELOPMENT COMMITTEE

A. THE COMMUNITY BASED TEAM SHALL STUDY THE EXISTING SERVICE DELIVERY SYSTEM FOR ABUSING AND NEGLECTING FAMILIES IN ORDER TO DETERMINE THE COMMUNITY'S PROBLEMS, SIGNIFICANT GAPS OR OVERLAPS, AND OBSTACLES TO DEVELOPMENT OF A COORDINATED PROGRAM.

- Elements of the system that should be studied include:

  1. identification and reporting.

  2. investigation.

  3. diagnosis and treatment planning.

  4. long- and short-term treatment and follow-up.

  5. training of professionals.

  6. community education.

  7. prevention.

- The study should include not only those organizations and individuals currently providing services, but also any others in the community that could provide preventive or treatment services.

- Recommendations should be sought from any existing case consultation committee(s) and human services planning groups in the community.

- Information on problems and needs should also be elicited from clients, e.g., Parents Anonymous groups or Client Involvement Committees.

- The study should examine procedures for coordination within and among agencies and organizations.

- Each organization represented on the team may wish to assess its internal service capability, administrative procedures, planning and funding resources and commitment to the team process before assuming responsibilities within the team's plan.

B. BASED ON THE FINDINGS AND CONCLUSIONS OF THE STUDY, A PLAN SHALL BE DEVELOPED TO SUPPORT A COMMUNITY SYSTEM FOR THE PREVENTION, IDENTIFICATION AND TREATMENT OF CHILD ABUSE AND NEGLECT.

- The plan should establish a framework for cooperative community structures to prevent and treat child abuse and neglect.

- This plan should include:

  1. measurable goals (long-term, intermediate and short-term).

  2. priorities.

  3. operational objectives.

  4. specific action steps.

- The plan should consider adaptation of existing services as well as development of new ones.

- Recommendations for coordination at case consultation and program development levels should be included.

C. THE COMMUNITY BASED TEAM SHALL ASSIST THE COMMUNITY (INCLUDING ITS POLITICAL LEADERSHIP), THE GOVERNOR'S ADVISORY COMMITTEE, AND THE LEGISLATORS IN UNDERSTANDING CHILD ABUSE AND NEGLECT AS WELL AS IN FORMULATING AND EFFECTING LEGISLATION AND REALISTIC APPROPRIATIONS FOR SERVICES TO ABUSING AND NEGLECTING FAMILIES.

- The team should inform the community and its leadership of the results of its needs assessment study.

- The team should seek support for its comprehensive plan among various public and private organizations as well as with political leaders.

D. THE COMMUNITY BASED TEAM SHALL SET THE DIRECTION FOR SOCIAL ACTION THROUGH THE DEVELOPMENT OF PUBLIC POLICIES THAT STRENGTHEN FAMILY LIFE, IN ORDER TO ALLEVIATE THE ECONOMIC AND SOCIAL CONDITIONS THAT CONTRIBUTE TO THE PROBLEM OF ABUSE AND NEGLECT.

A thorough study must be undertaken before an effective plan can be developed. The study should consist of a compilation of relevant statistical information as well as opinions and the analysis of these to determine problems. It is crucial that real needs based on facts be identified. The problems that appear most obvious may be those for which a solution is already known and may not reflect the more critical problems underlying the service delivery system that should be addressed in the plan. The more directly each goal can be related to a specific part of the problem, the more successful planning efforts will be. It is difficult to develop realistic long-range goals because changes in conditions upon which they are based are not always predictable. It is important, however, that teams attempt long-range planning to set the over-all framework of their short-term goals and efforts. It is also essential that the team establish priorities among its goals to reduce confusion about which activity is more important and to provide direction on where scarce resources can most effectively be used. In doing this, the team should always keep in mind the interdependence of various activities.

Adaptation of existing resources as well as development of new resources should be considered. Existing day-care programs might, for example, reserve a number of slots for

abused or neglected children after securing training for program staff. Voluntary organizations and church groups also sponsor programs that might be adapted to the needs of abusing and neglecting families.

The plan should include a description of existing coordinating procedures, such as referrals, sharing of information, and terminating of cases, and should make recommendations for changes if needed.

VII. CASE CONSULTATION COMMITTEE

A. ANY MEMBER OF THE COMMITTEE OR HIS DESIGNEE MAY PRESENT A CASE TO THE CASE CONSULTATION COMMITTEE. THE LOCAL WELFARE AGENCY SHALL DETERMINE WHICH OF ITS CASES ARE IN NEED OF THE COMMITTEE'S ASSISTANCE. THE LOCAL WELFARE AGENCY MUST BE ULTIMATELY RESPONSIBLE FOR DEVELOPING AND IMPLEMENTING SERVICE ON ITS CASES.

- Appropriate cases to be brought to the Case Consultation Committee should be situations where the specific treatment needs are not clear, where it is questionable whether the child can safely remain at home, where a permanent plan of foster care or adoption is to be considered, or where numerous community resources and treatment services must be coordinated.

B. THE CASE CONSULTATION COMMITTEE SHALL ASSIST THE LOCAL WELFARE AGENCY IN MAKING A COMPREHENSIVE DIAGNOSIS AND TREATMENT PLAN FOR EACH CASE PRESENTED TO THE COMMITTEE. THE COMMITTEE SHALL ASSIST IN MOBILIZING AND COORDINATING SERVICES TO MEET BOTH SHORT AND LONG TERM TREATMENT GOALS.

- The Case Consultation Committee shall assist by:

1. collecting relevant information on the child and family members to validate a complaint or report; to the greatest extent possible, information should be collected directly from the family.

2. providing a forum to integrate information and identify potential problems in service delivery.

3. assessing needs, strengths and priority problems of the child and family members.

4. recommending short- and long-range treatment plans and matching needs with appropriate resources.

5. coordinating referrals to available resources.

6. promoting development of needed resources.

7. determining when a case is to be presented for another review.

8. developing a recall system to assure that cases will be reviewed at predetermined intervals.

9. determining when a case can be safely terminated.

C. THE CASE CONSULTATION COMMITTEE SHALL INSURE THAT APPROPRIATE FEEDBACK IS PROVIDED TO INDIVIDUALS WHO REPORT SUSPECTED CHILD ABUSE OR NEGLECT SITUATIONS, WHERE THIS IS ALLOWED BY LAW.

- The State Department of Welfare, Social Service Manual outlines procedures for providing such feedback. In addition, the committee could determine other feedback methods; e.g., a reporting professional might attend diagnostic and/or treatment review conference.

D. THE CASE CONSULTATION COMMITTEE SHALL ENCOURAGE COORDINATED EFFORTS AMONG AGENCIES AND INDIVIDUALS WHO ARE RENDERING DIRECT SERVICES TO A FAMILY. WHEN SERIOUS PROBLEMS OF COORDINATION OR SERVICE DELIVERY OCCUR, THE CASE SHOULD BE REVIEWED BY THE COMMITTEE.

- Initially, service providers would convene to clarify their respective roles and set intervals for progress conferences. Each provider would accept responsibility for communicating with other providers whenever indicated, e.g., when a family crisis warrants concerted action. Providers will want to consider the advisability of involving family members in conferences when appropriate.

  When a conflict between providers cannot be resolved, it would be in the family's best interest for the case to be reviewed by the Case Consultation Committee.

VIII. PARENTS' AND CHILDREN'S RIGHTS

A. THE CASE CONSULTATION COMMITTEE SHALL AT ALL TIMES REMAIN AWARE OF THE NEED TO PROTECT THE RIGHTS OF PARENTS AND CHILDREN IN THE PRESENTATION OF CASES BEFORE THE COMMITTEE.

- All committee members shall become familiar with State legislation and agency regulations regarding confidentiality in child abuse and neglect cases. Minimally, the Case Consultation Committee shall adhere to the Privacy Protection Act of 1976, Section 2.1-377 through 2.1-386 of the Code of Virginia.

- Any information shared concerning the child and his/her family shall safeguard to the greatest extent possible, the privacy rights of the individual involved.

B. DUE TO THE PRIVACY PROTECTION ACT, IT IS RECOMMENDED THAT TEAM MEMBERS SIGN A WRITTEN STATEMENT THAT GUARDS THE CONFIDENTIALITY OF ALL INFORMATION REVEALED DURING TEAM DISCUSSIONS.

IX. INTER-AGENCY AGREEMENTS

A. THE TEAM SHALL OBTAIN WRITTEN AGREEMENTS OF COOPERATION FROM THE AGENCIES AND ORGANIZATIONS WITHIN THE COMMUNITY'S SERVICE DELIVERY SYSTEM.

- Local interagency agreements should reflect any agreements existing between State agencies.

- Agreements should be based on the results of the study and comprehensive community plan developed by the team.

- Agreements should include:

  1. methods for formal and informal communication among staff.

  2. referral procedures.

  3. criteria for cases to be accepted by each.

  4. the roles agencies will play in identifying and reporting cases, providing various types of treatment and day-to-day management of cases.

  5. procedures for sharing information on diagnosis and progress of cases with which more than one agency is working.

  6. mechanisms for resolving conflicts that might arise among staff working on a case.

B. THE AGREEMENTS SHALL RECOGNIZE THE LOCAL WELFARE AGENCY'S NEED FOR SUFFICIENT INVOLVEMENT IN CASES TO CARRY OUT ITS LEGAL MANDATE.

- The team should insure that the local welfare agency's authority and responsibilities are observed.

  It is essential that the team insure that all agreements reflect the legal mandate of the local welfare agency; for example, the local welfare agency is given the authority to investigate all reported cases of suspected abuse and neglect.

C. THE TEAM SHOULD ENCOURAGE CONFERENCES AMONG COOPERATING AGENCIES ON A REGULAR BASIS TO DISCUSS PROBLEMS AND RECOMMEND CHANGES IN PROCEDURES AS NECESSARY.

- Administrators of cooperating agencies should meet quarterly to review progress in implementing the comprehensive community plan.

- Agreements should be reviewed and revised as necessary.

X. PROGRAM EVALUATION/RESEARCH

A. THE COMMUNITY BASED TEAM SHALL ENCOURAGE ALL AGENCIES TO MAINTAIN AND SHARE THE TYPES AND AMOUNT OF DATA NECESSARY FOR PLANNING AND EVALUATION OF PROGRAMS.

- This information should include:

  1. the number and sources of referrals.

  2. the number of valid cases.

3. the type of abuse and neglect.

4. the number of cases terminated and the reason.

5. the number of repeated cases.

6. the types of services provided by organization.

7. the number of organizations providing services.

8. the number of individuals providing services.

9. the number of case conferences held.

10. the number of joint treatment plans developed.

11. the number and types of training programs.

12. the number and types of public awareness programs.

B. THE COMMUNITY BASED TEAM SHALL REGULARLY PERFORM A REVIEW AND EVALUATION OF THE COMMUNITY'S OVER-ALL SERVICE DELIVERY SYSTEM WITH EMPHASIS ON THE EFFECTIVENESS, EFFICIENCY AND ACCEPTABILITY OF SERVICES FOR CHILD ABUSE AND NEGLECT CASES.

- Effective planning for child abuse and neglect services is based on regular evaluation of community programs and their effects on families.

C. THE COMMUNITY-BASED TEAM SHALL DEVELOP METHODS FOR REVIEWING AND EVALUATING THE EFFECTIVENESS WITH WHICH SERVICES ARE BEING COORDINATED AND UTILIZED.

- The team should designate persons skilled in evaluation methods to assist with this evaluation.

- The team should determine how a representative sample of cases is to be selected and assist with selection of cases for review.

- The team should spell out criteria for determining effective and noneffective use of services by clients; e.g., number of appointments made, kept, broken, accessibility of service, completeness of treatment plan, regularity with which treatment plan is reviewed and updated.

- The team should determine how often such reviews should be conducted.

- The team should be responsible for writing and distributing a report of findings and recommendations to improve service utilization and coordination.

D. THE COMMUNITY BASED TEAM SHALL COOPERATE WITH INDIVIDUALS AND GROUPS CONDUCTING BONAFIDE RESEARCH ON CHILD ABUSE AND NEGLECT BY PROVIDING APPROPRIATE INFORMATION.

- The teams should be assured that the purpose of research is valid.
- Only nonidentifying information should be released.
- The teams should insure that the researcher is following acceptable research standards such as those governing the protection of human subjects.
- Cooperation with appropriate research gatherers may result in valuable planning and evaluation assistance to the team.

Child Abuse Model Standards and Guidelines

FOR MULTIDISCIPLINARY TEAMS IN PENNSYLVANIA

TABLE OF CONTENTS

		Page
INTRODUCTION		1
PREFACE		3
LEGAL MANDATE		4
ACKNOWLEDGEMENTS		4
MODEL FOR PENNSYLVANIA		5
STANDARDS AND GUIDELINES		
I.	Team Functioning/Organizational Issues	7
II.	Team Composition	9
III.	Citizen Participation	11
IV.	Area/Coverage	12
V.	Community Standards of Care	12
VI.	Program Planning/Development	13
VII.	Case Consultation	18
VIII.	Parents/Children's Rights	21
IX.	Program Evaluation/Research	23

INTRODUCTION

This handbook is intended to assist county child welfare agency staffs and other interested parties to develop and improve Multidisciplinary Team services to abused and neglected children and their families.

On October 1, 1976 Frank S. Beal, Secretary of the Department of Public Welfare, requested top level staff assistance from various State Departments to join with the Department of Public Welfare to establish a State level Multidisciplinary Team.

The Team's major goal for 1976-77 was to develop a model with standards and guidelines for use by county child welfare agencies in establishing a county Multidisciplinary Team. This booklet represents the Team's efforts at pulling together all the general ideas on the Multidisciplinary Team concept and adapting them to Pennsylvania's law and particular needs.

The following individuals were assigned to represent their respective departments on this Statewide Team:

DEPARTMENT OF JUSTICE
Attorney General's Office
Mr. Paul Schilling, Deputy Attorney General

JUVENILE COURT JUDGES COMMISSION
Honorable Harvey N. Schmidt

DEPARTMENT OF EDUCATION
Ms. Frances DeWitt, Special Assistant,* Deputy Secretary's Office
Mr. John Christopher, Director, Bureau of Instructional Support Services
Ms. Marian Lohr, Coordinator**, School Health Services

DEPARTMENT OF HEALTH
Dr. Annette Lynch, Director, Bureau of Children's Services

PENNSYLVANIA STATE POLICE
Captain Salvador Rodrequez, Director, Community Relations Division

GOVERNOR'S COUNCIL ON DRUG & ALCOHOL ABUSE

Mr. Peter Pennington, Executive Assistant Director
Ms. Debbie Metz, Co-member**

DEPARTMENT OF PUBLIC WELFARE

Office of Mental Health:
Dr. Alan Handford, Director, Children & Youth Services
Dr. James Reisinger, Staff Assistant
Office of Mental Retardation:
Ms. Carol Chalick, Chief, Division of Preventive Services
Office of Children and Youth:
Mr. Joseph Spear, Child Welfare Specialist***
Mr. Lee Miller, Administrator, ChildLine

FEDERAL REGION III

Mr. Gary Koch, Child Development Specialist, Department of Health, Education & Welfare

DEVELOPMENT ASSOCIATES

Ms. Patricia Vasquez, Project Director, Development Associates

I thank those Team Members who took time, including weekends, from their busy schedules and contributed valuable information and assistance to us.

We hope the remaining pages of information are meaningful to you and we welcome your comments.

Gordon Johnson, Team Coordinator
Director, Bureau of Child Welfare

* Resigned from the Team
** New Member
*** Assistant Team Coordinator

PREFACE

The management of child abuse cases cuts across various professional disciplines and at one time or another may require the expertise of physicians, social workers, attorneys, psychologists, nurses, etc. With this in mind the concept of the Multidisciplinary Team was developed to prevent confusion to the child and parents and to allow the various professionals involved to work cooperatively for the betterment of all concerned. The treatment approach can be planned and implemented and services increased or decreased as the need arises. Through proper case management by the Team, the child can be maintained in his/her home environment with minimal risk and maximum treatment benefits.

The use of Multidisciplinary Teams also removes the awesome decisions and responsibilities from one person and distributes the responsibility among the various Team members. Since it does transcend one profession, it is appropriate that all professions involved in a particular case should meet to discuss the best approach to helping each particular family.

The use of Multidisciplinary Teams has the added advantage of minimizing the confusion to the client because it presents a systemized approach and coordinates the activities of all concerned and involved. This prevents a flood of helping persons from visiting the family and offering services which may be in direct contradiction to one another. It allows one person to take the leadership role with a particular family and to coordinate and arrange for other services as they are needed or indicated.

Multidisciplinary Teams can serve another valuable function for both the community in general and the child welfare agency administrator in particular by identifying gaps in service in the community and working to see that the necessary services are developed to fill this void. The Multidisciplinary Team can either develop these services directly or use their influence to convince the appropriate political structure that expansion or development of services is necessary.

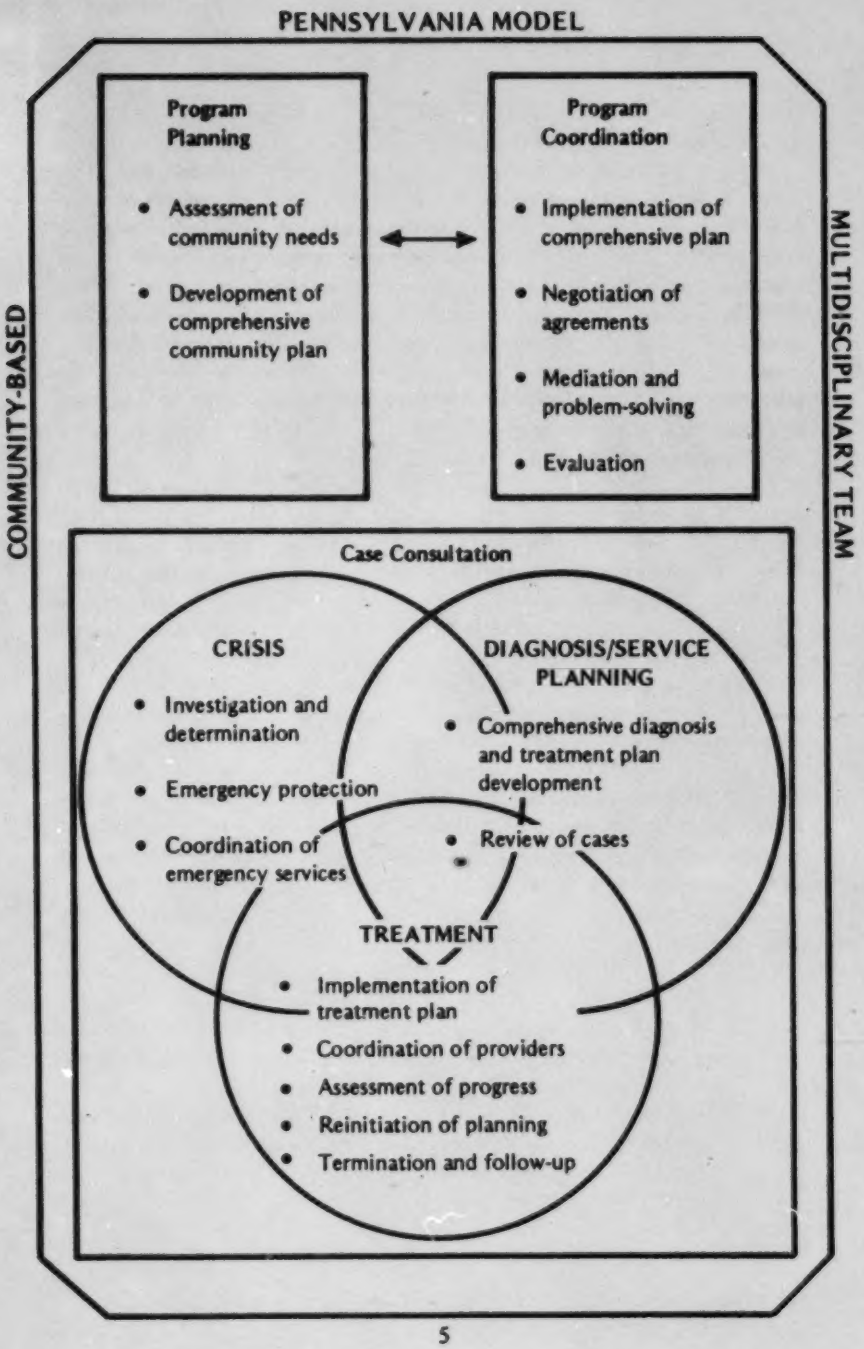
Legal Mandate:

The Child Protective Services Law, Act of November 26, 1975, P.L. 438 (No. 124) mandates each county's child protective service to make available among its services for the prevention and treatment of child abuse the benefits of a Multidisciplinary Team. Attending departmental regulations, Chapter II, Section 23, stipulate that the Child Protective Service shall consult with and utilize the services of professional disciplines within their communities such as health, mental health, social services, education, law and law enforcement for the purposes of developing, reviewing, and implementing treatment plans for abused children and their families, and for receiving recommendations as to the improvement of overall service delivery by the Child Protective Service.

Acknowledgements:

In 1974 Congress enacted the Child Abuse Prevention and Treatment Act which made available for the first time monies to be used specifically for research and training in the area of child abuse and neglect. Part of this money was used to develop a contract with Development Associates, Inc., a Management and Governmental Consulting Firm located in Washington , D.C. The purpose of this contract was to conduct needs assessment surveys in all ten Federal Regions to ascertain what state and county agencies perceived as their greatest need in delivering services to abused and neglected children. The consensus of the various professions engaged in the planning and delivery of services to abused and neglected children in Region III was that there was a need for assistance in planning for and carrying out the roles of a Multidisciplinary Team as well as staff development assistance for the various state agencies involved in serving abusing and neglecting families.

The Office of Child Development which is implementing this act awarded a second contract to Development Associates to assist the states in Region III in developing a state model for Multidisciplinary Teams based on the uniqueness of each state's law and administrative structure for delivering services to abused children and their parents. The first step in this process was to designate a Team composed of the various professions that carried program planning and development responsibilities for child abuse at the state level. One of the functions of this team was to develop the following model and guidelines for local communities to use in developing Multidisciplinary Teams. The Bureau of Child Welfare in the Department of Public Welfare was assigned primary responsibility to coordinate the activities of this Team.


PENNSYLVANIA MODEL
COMMUNITY-BASED
MULTIDISCIPLINARY TEAM
Program Planning
• Assessment of community needs
• Development of comprehensive community plan
Program Coordination
• Implementation of comprehensive plan
• Negotiation of agreements
• Mediation and problem-solving
• Evaluation
Case Consultation
CRISIS
• Investigation and determination
• Emergency protection
• Coordination of emergency services
DIAGNOSIS/SERVICE PLANNING
• Comprehensive diagnosis and treatment plan development
• Review of cases
TREATMENT
• Implementation of treatment plan
• Coordination of providers
• Assessment of progress
• Reinitiation of planning
• Termination and follow-up

5

DESCRIPTION OF THE PENNSYLVANIA MODEL: COMPONENTS OF SERVICE

The schematic on page five (5) is a functional model for community-based teams – that is, it outlines the essential, interdependent functions necessary to a coordinated community approach to child abuse. The organizational structure adopted by different communities, however, will differ with their characteristics and needs. One community might, for example, develop a single group to undertake these functions while another might develop a number of highly specialized subcommittees. A team might also be composed of permanent members who meet regularly and consulting members who undertake a specific task or who bring special knowledge or skills needed for an individual case consultation.

It is anticipated that the process of implementing the total model will be a gradual one, with each community determining which functions it will address first. Because of any number of variables, counties are in a continuum in establishing MDT's. The Department of Public Welfare does not expect every county to implement MDT as described in this booklet. The purpose of the model, standards and guidelines is to assist communities in establishing a MDT. Counties are not required to develop their MDT's after the model described herein, but encouraged to take those parts or suggestions that would be of benefit to them.

This book should be considered as a beginning. Comments on its usefulness and suggested techniques would be appreciated.

I. **Team Functioning/Organizational Issues**

A. THE COMMUNITY-BASED TEAM SHALL HAVE A WRITTEN STATEMENT CLEARLY DELINEATING ITS MISSION OR PURPOSE AND MEASURABLE GOALS.

1. The team should establish priorities among its goals and objectives which should include the following:

   - review and assess community needs and resources
   - assist the child welfare agency in the development of its local plan
   - assist in developing needed resources
   - develop public awareness of the problem of child abuse
   - develop a component to provide consultation to the child welfare agency in specific cases
   - assist in the identification and development of interagency relationships
   - assist in educating organizations and individuals in identifying and reporting suspected child abuse
   - seek citizen participation (Sec. III, Citizen Participation)

2. Specific objectives leading to the achievement of each goal should be identified.

3. Specific action steps, members' responsibilities and deadlines should be outlined.

B. THE COMMUNITY-BASED TEAM SHALL HAVE A WRITTEN STATEMENT OF HOW IT WILL OPERATE (OR A CONSTITUTION AND BY-LAWS IF MORE FORMAL STRUCTURE IS REQUIRED).

1. The statement should include:

   - a method of nominating and selecting officers
   - responsibilities of officers and members
   - term of service for officers and members
   - frequency, times and locations of meetings
   - whether meetings are open or closed to the public
   - a set of ground rules for the conduct of meetings
   - attendance at meetings
   - use of subcommittees

C. THE COMMUNITY-BASED TEAM, NOT THE INDIVIDUAL MEMBERS, SHALL BE PERMANENT SINCE EFFECTIVE PLANNING AND COORDINATION ARE A COMPLEX AND DYNAMIC PROCESS.

D. THE COMMUNITY-BASED TEAM SHALL SEEK THE SUPPORT OR SANCTION OF GOVERNMENTAL GROUPS IN THE COMMUNITY.

1. The community-based team should advise the political leadership of its efforts and provide periodic reports on its progress.

2. Plans and mechanisms for coordination of efforts with other pertinent public and voluntary citizens' committees should be developed by the team.

3. Firm linkages should exist between program planning/coordination and case coordination.

4. The team should meet regularly with the administrators of cooperating programs to review progress being made in the development of a coordinated service delivery system.

COMMENTS

The purpose of developing by-laws or statements of operation is to provide clarity in goals and objectives as well as a permanent structure for the team. Equally important is a clear understanding of how the team is to operate. Each member should understand his or her responsibilities as well as such ground rules as how decisions are to be made. The team can also begin to build a support base in the community by informing the political leadership, other significant public and voluntary citizens' committees or councils as well as the community at large of its goals and progress in achieving them.

II. Team Composition

A. THE COMPOSITION OF THE COMMUNITY-BASED TEAM SHALL REFLECT THE RANGE OF AMELIORATIVE AND TREATMENT RESOURCES AVAILABLE TO ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES.

1. Representatives from the fields of social service, health, mental health, education, law enforcement, legal profession, and elected governmental officials should be included.

2. In areas where military bases are located, a representative of this sector should be included.

3. There should be representatives from the community at large (non-agency members) selected on the basis of geographical distribution; community patterns of ethnic background, income levels, educational levels, and occupations, as well as willingness to serve, expertise, and concern.

B. QUALIFICATIONS OF TEAM MEMBERS SHALL INCLUDE THE ABILITY TO CONTRIBUTE TO THE SOLUTION OF PROBLEMS AND TO CARRY OUT THE RESPONSIBILITIES OF MEMBERSHIP THROUGH A WILLINGNESS TO SERVE ON A CONTINUING BASIS. MINIMALLY, MEMBERS SHALL HAVE DEMONSTRATED AN INTEREST IN AND CONCERN ABOUT CHILD ABUSE AND NEGLECT.

1. Members who represent agencies should be persons of sufficient stature that their actions reflect their agencies' policies. At the program coordination level, these members should be administrators; at the case level, supervisory and direct service staff. In either case, members should be able to make commitments on behalf of their individual organizations.

COMMENTS

The initial composition and size of a team will most often be determined by its purpose and goals as well as by the level of interest and commitment on the part of agencies and individuals. A team should strive to incorporate all organizations in the community which are or which could be providing ameliorative and treatment services. While a team should be large enough to be representative of the area it serves, caution must be taken so that it does not become unwieldy. A team might, for example, be composed of permanent and consulting members or might use mechanisms such as ad hoc committees.

If a community-based team is to become a realistic and effective joint planning and decision-making body, it is critical that members appointed by various organizations have the authority to represent their agencies' interests and points of view. Members should be able to stimulate implementation of plans by influencing the necessary political and administrative action and financing.

III. Citizen Participation

A. THE COMMUNITY-BASED TEAM SHALL DEVELOP MECHANISMS TO SEEK CITIZEN PARTICIPATION IN ORDER TO ENSURE AN ACCURATE VIEW OF AREA NEEDS AND PATTERNS AS WELL AS CITIZENS' SUPPORT OF PROGRAMS WITH THEIR IDEAS, LABOR, FUNDS, AND UTILIZATION OF THE SERVICES.

1. The team should identify sources of leadership in both the public and private sector.

2. The team should identify persons or groups in the community which do or could help in preventing child abuse and neglect.

3. The team should identify social and economic problems or patterns in the community which contribute to the problem of child abuse and neglect.

4. The team should make reports to the community detailing problems and needs, program plans and progress, and recommendations for changes needed to improve service effectiveness.

5. Team meetings dealing with community needs assessment, program planning, and program evaluation must be open to the public.

6. The team should develop linkages with voluntary organizations and citizens' groups.

7. The team should assist in the development of public awareness and education campaigns.

IV. Area/Coverage

A. THE CPS IN ALMOST ALL CASES FUNCTIONS ON A SINGLE COUNTY BASIS. HOWEVER, THE COMMUNITY-BASED TEAM MAY DEFINE ITS SERVICE AREA DIFFERENTLY, BASED ON SUCH FACTORS AS:

1. Sufficient population base;
2. Necessary financial resources;
3. Linkage through common business and social interests and transportation systems;
4. Political boundaries;
5. Existing service delivery boundaries or catchment areas.

COMMENTS

One of the first decisions which a team must make is the area which it will serve – a single county; sections of a large city; or, particularly in some rural areas, all or part of several counties. Factors such as the type of team, size of the population requiring services, proximity of the people to the services, team staffing and budgetary constraints will all affect this decision. The team should also determine whether or not the area chosen has common problems which are amenable to solution through joint efforts.

V. Community Standards of Care

A. THE COMMUNITY-BASED TEAM SHALL WORK WITH THE CPS IN DEVELOPING REALISTIC AND ATTAINABLE STANDARDS AND GUIDELINES COMPATIBLE WITH EXISTING REGULATIONS FOR USE BY COOPERATING AGENCIES AND INDIVIDUAL PROFESSIONS IN WORKING WITH CHILD ABUSE/NEGLECT CASES.

1. The standards and guidelines should include at least the following areas:

   - criteria for treatment plans
   - minimum frequency of contacts with families
   - criteria for format and timing of case review
   - criteria for maximum caseload size--for team and type of staff
   - criteria for determining timing and procedures for termination of stabilization of cases
   - time between maximum progress and termination/stabilization
   - policies re follow up of terminated/stabilized cases
   - procedures for monitoring follow up contacts

COMMENTS

The team should bear in mind that if standards are set too low, they may be easily achieved but may restrict progress. On the other hand, standards that are set too high may not be attainable in some communities, and frustration can be the result. By determining desirable patterns of services that are within the realm of reality and practicality, teams can measure needs by comparing existing patterns with the desirable ones. This process will provide the necessary groundwork for thorough program planning and development.

VI. Program Planning/Development

A. THE COMMUNITY-BASED TEAM SHALL IDENTIFY, REVIEW AND ASSESS COMMUNITY PROGRAMS FOR ABUSING AND NEGLECTING FAMILIES, WITH A VIEW TOWARDS DESCRIBING THE EXISTING SERVICE DELIVERY SYSTEM. THE TEAM SHALL DEVELOP A REPORT OUTLINING ITS CONCLUSIONS AS TO THE COMMUNITY'S PROBLEMS, SIGNIFICANT GAPS OR OVERLAPS, AND OBSTACLES TO THE DEVELOPMENT OF A COORDINATED SERVICE DELIVERY SYSTEM.

THE DEVELOPMENT OF A COORDINATED SERVICE DELIVERY SYSTEM.

1. The elements of a coordinated system include:

   - identification and reporting
   - investigation
   - diagnosis and treatment planning
   - long and short term treatment and follow up
   - training of professionals
   - community education
   - prevention
   - program evaluation and monitoring

2. The review and assessment should include not only those organizations and individuals currently providing services but also others in the community which could provide ameliorative or treatment services.

3. Input should be sought from any human service agencies and/or planning groups in the community.

4. Information on problems and needs should be sought from clients of the service delivery system.

5. The team should review coordination procedures within and among agencies.

6. The report on conclusions should describe the procedures currently used to serve abusing and neglecting families, the types of services provided, and the agencies providing services. The assessment should consist of relevant statistical information as well as opinion, and the analysis of these to determine problems.

B. BASED ON THE CONCLUSIONS AND FINDINGS OF THE REVIEW AND ASSESSMENT, A COMPREHENSIVE COMMUNITY PLAN SHALL BE DEVELOPED TO STRENGTHEN THE SERVICE DELIVERY SYSTEM.

1. The plan should establish roles and responsibilities for cooperative community structures to prevent and treat child abuse and neglect.

2. The plan should recognize Child Welfare's mandate and legal responsibility to establish and maintain a MDT.

3. The plan should include:

   - measurable goals (short term, intermediate, and long term)
   - priorities
   - operational objectives
   - specific action steps to be undertaken by the team
   - mechanisms for ongoing evaluation

4. The plan should consider adaptation of existing services as well as development of new ones.

5. Recommendations for coordination needed at both the program or system level and case level should be included.

6. The broadest possible community participation should be sought in the development of the plan.

7. This plan should include recommendations to assist the agency director in developing the "Local Plan."

C. THE COMMUNITY-BASED TEAM SHALL ASSIST THE COMMUNITY, LOCAL CITY AND COUNTY GOVERNMENTAL OFFICIALS AND STATE LEGISLATORS IN UNDERSTANDING CHILD ABUSE AND NEGLECT AND IN THE FORMULATING OF LEGISLATION AND REALISTIC APPROPRIATIONS FOR SERVICES TO ABUSING AND NEGLECTFUL FAMILIES.

1. The team should inform the community and its political leadership of the results of its needs assessment.

2. The team should be an advocate for its comprehensive plan with public and private agencies and the political leaders.

3. The team should participate in the public hearings for the local plan.

D. THE COMMUNITY-BASED TEAM SHALL SET THE DIRECTION FOR SOCIAL ACTION TO IMPROVE THE ECONOMIC AND SOCIAL CONDITIONS WHICH CONTRIBUTE TO THE PROBLEM OF ABUSE AND NEGLECT THROUGH THE DEVELOPMENT OF PUBLIC POLICIES WHICH STRENGTHEN FAMILY LIFE.

E. THE TEAM SHALL OBTAIN WRITTEN AGREEMENTS FROM THE AGENCIES AND ORGANIZATIONS WITHIN THE COMMUNITY'S SERVICE DELIVERY SYSTEM SPECIFYING THEIR ROLE IN IMPLEMENTING THE COMPREHENSIVE COMMUNITY PLAN.

1. The agreements might include:

- referral procedures
- criteria for cases to be accepted by each
- procedures for sharing information on the diagnosis and progress of cases involving more than one agency
- mechanisms for regular review of agreements and revision as necessary
- procedures for joint staff training
- financial agreements

COMMENTS

A thorough needs assessment must be undertaken before an effective plan can be developed. It is crucial that real needs based on facts, not merely opinion be identified. The problems which appear most obvious may be those for which a solution is already known and may not reflect the more critical problems underlying the service delivery system which should be addressed in the plan.

The more directly that a goal can be related to a specific part of a problem, the more successful planning efforts will be. Although it is difficult to develop realistic long-range plans because changes in conditions upon which goals are based are not always predictable, it is important that community-based teams attempt long-range planning to set the overall framework of their shorter term goals and efforts. It is also essential that the team establish priorities among its goals to reduce confusion as to which activity is most important and to provide direction as to where scarce resources can best be used. In doing this, the team should always keep in mind the interdependence of various activities.

Using the service delivery standards, data from their needs assessment, and the comprehensive plan as a foundation, the team should seek appropriate agreements from all of the organizations in the service delivery system, specifying their roles and responsibilities and how they will interface with others. Most organizations have written policies and regulations which govern their actions and determine the area they serve, clients served, and kinds of services provided. The inter-agency agreements will serve as mechanisms for implementing the comprehensive community plan.

VII. Case Consultation

THE COMMUNITY-BASED TEAM SHALL OFFER THE SERVICES OF MULTIDISCIPLINARY CASE CONSULTATION GROUP(S) TO THE CHILD WELFARE AGENCY. WHEN THE AGENCY UTILIZES SUCH CONSULTATION, THE MULTIDISCIPLINARY GROUP BECOMES A PART OF THE CHILD PROTECTIVE SERVICES. AS SUCH THEY ARE BOUND BY THE SAME CONFIDENTIALITY STRICTURES AS THE CPS STAFF.

* Multidisciplinary consultation should be available during the three basic phases of the management of child abuse cases - crisis intervention, diagnosis/treatment planning, and treatment implementation.

* Depending on a county's characteristics and its needs, the community based team might develop one group which could coordinate services in each of the three phases; or it might develop a number of specialized groups.

* The multidisciplinary consultation group(s) should provide a forum for the sharing of appropriate information on diagnosis, treatment plans and progress among professionals involved with a child abuse case.

* The multidisciplinary group(s) should ensure that information on problems of coordination and needs for resources is shared with program planning and coordination components of the community based team.

THE LOCAL CHILD WELFARE AGENCY SHALL DETERMINE WHICH CASES ARE IN NEED OF A MULTIDISCIPLINARY CASE CONSULTATION GROUP'S ASSISTANCE.

* Appropriate cases for referral to a multidisciplinary group should include those where it is questionable whether or not a child can safely remain in the home, where specific treatment needs are not clear, where it is questionable whether or not a child can be safely returned to the home, or where numerous community resources and treatment services must be coordinated.

MULTIDISCIPLINARY CONSULTATION GROUPS DEALING WITH CRISIS INTERVENTION SHALL INCLUDE THOSE PROFESSIONALS NECESSARY TO ASSIST CPS WITH ITS INVESTIGATION, PROVIDE IMMEDIATE PROTECTION TO THE CHILD, AND COORDINATE EMERGENCY SERVICES TO THE FAMILY.

* A crisis group should meet when child abuse is suspected and pool and evaluate available information in order to make two critical decisions -- do the injuries seem to indicate child abuse and is the home safe for the immediate return of the child.

* The crisis group should coordinate the provision of emergency services to ensure that the family is served more efficiently in times of crisis by the various disciplines without long waits for services. Services might include short term counseling, medical assistance, emergency homemaker or child care, emergency financial assistance, family shelters, crisis nursery, emergency removal and placement of the child.

* The crisis group should ensure that duplicate investigations of a family do not occur, i.e., that information already collected is used where possible and allowable by law.

THE MULTIDISCIPLINARY GROUP PROVIDING CONSULTATION TO CPS ON DIAGNOSIS AND THE DEVELOPMENT OF TREATMENT PLANS FOR CHILD ABUSE CASES SHALL INCLUDE ONLY PROFESSIONALS WITH THE REQUIRED EXPERTISE TO FULFILL THE PURPOSE OF THE GROUP, I.E. ASSESSING MEDICAL, PSYCHOLOGICAL, LEGAL, AND SOCIAL ASPECTS OF COMPLEX CASES AND DEVELOPING A COMPREHENSIVE TREATMENT PLAN.

- The group should include skilled representatives of the various disciplines who will meet regularly as a core group to provide consultation to CPS on cases as well as ad hoc consulting members who have knowledge or a special skill needed for a particular case. The specific professions represented on the core group will vary with availability as well as the contribution they may be expected to make to the team. Where possible, professionals should be drawn from local treatment agencies in order to provide a referral liaison between the team and agency.

- This group should assist the CPS by developing a comprehensive diagnosis and treatment plan for each case referred to it. The plan should include:

  a. a statement of the specific problems a family has and possible causes
  b. an assessment of the needs and strengths of the family
  c. treatment goals, short and long range objectives--with dates
  d. identification of resources to be used
  e. a schedule for providing services, coordinating the needs of a family and those of the service providers
  f. a schedule for reviewing treatment progress
  g. designation of a case monitor to maintain frequent and supportive contact with the family and service providers.

- This group should also assist in:

  a. identifying and resolving potential problems in service delivery
  b. developing a recall system to ensure that cases will be reviewed at predetermined intervals
  c. reviewing a representative sample of cases to assess whether services are being utilized as planned and whether agencies are responsive to referrals of abusing families
  d. ascertaining reasons for inadequate utilization of services
  e. developing procedures for intervening when serious problems of coordination of service delivery occur.

COMMENTS

The county child welfare agency should assume the leadership role in establishing a MDT in the county. If there are two or more component groups, a member of the CPS does not necessarily have to be chairperson of each component. Because the CPS has the legal mandate to provide protective services, a member of the CPS should be directly responsible for the Case Management Component.

VIII. Parents'/Children's Rights

THE CASE MANAGEMENT TEAM SHALL ADHERE TO THE CPS LAW AND REGULATIONS CONCERNING THE RIGHTS OF PARENTS AND CHILDREN INCLUDING BUT NOT LIMITED TO THE FOLLOWING.

* Their rights to confidentiality of information.
* Their right to legal representation at any stage of the proceeding.
* Their right to receive all necessary treatment and social services to prevent future abuse and/or neglect if appropriate.
* Their right to court hearings for detention hearings, transfer of custody, etc.
* Their rights regarding amending, sealing, and expunging reports in which they are named.
* Children's right to admission to any public or private hospital for treatment
* Their right to a completed investigation within 30 days
* Children's right to protective custody
* Their right to appropriate and proper notification regarding receipt of the report status, changes, etc.

THE CASE MANAGEMENT TEAM SHALL ENDEAVOR TO INVOLVE THE PARENT(S) AND, IF APPROPRIATE, THE CHILD IN THE DIAGNOSIS AND TREATMENT PLANNING PROCESS AND DURING ONGOING REVIEWS.

* The team should invite the parent(s) and the child, if appropriate, to participate in meetings during which decisions are made about them.

* The case management team should develop procedures for assisting the family in understanding the results of meetings, decisions, and the status of the child.

* The team should endeavor to obtain the family's agreement to (or at least acknowledgement of) the treatment plan selected.

THE CASE MANAGEMENT TEAM SHALL DEVELOP A MECHANISM FOR CLIENT PARTICIPATION IN PROGRAM PLANNING AND EVALUATION.

COMMENTS

While the team must be guided by existing law and regulations regarding parents' and children's rights, it should give careful consideration to developing procedures for involving families in the decisions made about them in order to secure their cooperation in the treatment plan.

There has been increased legislative activity and litigation concerning the individual's right to privacy and freedom of information as well as parents' rights and professional malpractice. Case management teams should be aware of these trends in order to make fully informed decisions in regard to their own practices and procedures.

IX. Program Evaluation/Research

A. THE COMMUNITY-BASED TEAM SHALL ENCOURAGE ALL AGENCIES TO MAINTAIN THE TYPES AND AMOUNT OF DATA NECESSARY FOR PROGRAM PLANNING AND EVALUATION.

1. The team should have access to data such as:

- number of cases identified--by source
- number of cases investigated
- number of cases founded, indicated, unfounded
- classification of cases (type of abuse or neglect)
- amount of recidivism in founded and indicated cases
- number of organizations providing services -- by organization
- services provided--by organization
- cost of services--by type and per client
- number of case conferences held
- number of joint treatment plans developed
- number of cases terminated
- number of professional training sessions--by source
- number and types of public awareness endeavors
- other information as might be necessary e.g., age, sex, and location of child.

B. THE COMMUNITY-BASED TEAM SHALL REVIEW AND EVALUATE THE COMMUNITY'S OVERALL SERVICE DELIVERY SYSTEM FOR CHILD ABUSE/NEGLECT CASES ON A REGULAR BASIS--THE EFFECTIVENESS AND EFFICIENCY AS WELL AS THE ACCEPTABILITY OF SERVICES.

1. The team should establish mechanisms which will assure a regular means of securing feedback from all cooperating agencies providing services and from service recipients.

2. The team should build measurable factors into all goal statements.

C. THE COMMUNITY-BASED TEAM SHALL COOPERATE WITH INDIVIDUALS AND GROUPS WHO ARE CONDUCTING BONA FIDE RESEARCH ON CHILD ABUSE AND NEGLECT BY PROVIDING APPROPRIATE INFORMATION.

1. The team should ensure the confidentiality of clients by providing only non-identifiable information.

2. The team should ensure that the researcher is adhering to acceptable research practices such as those governing the protection of human subjects.

COMMENTS

In order to do effective planning, the team must evaluate, on a regular basis, the total system's effectiveness and efficiency as well as its impact on individual families. An assessment which includes management policies and procedures as well as service practices will provide the team with the data necessary to inform policy makers and the community at large of needs for progressive changes in policies and procedures as well as the need for additional and/or different resources.

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